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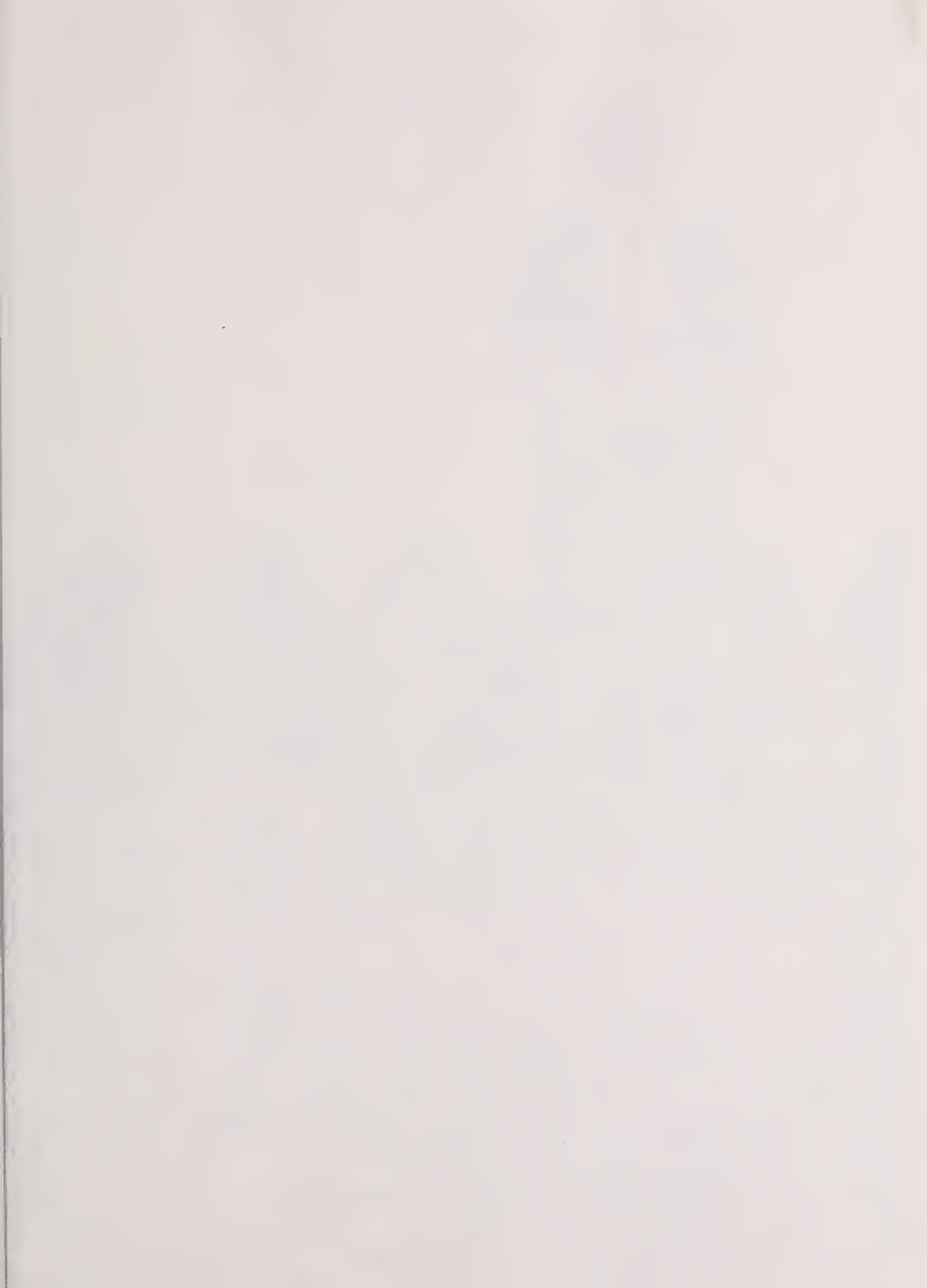


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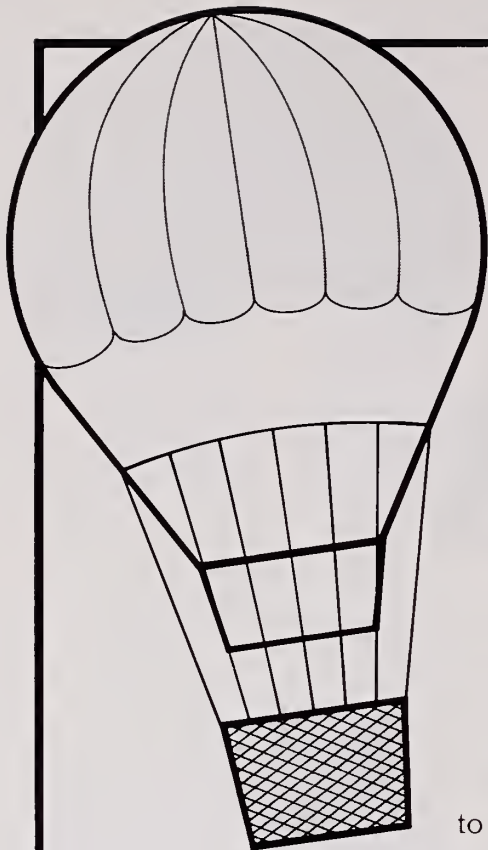


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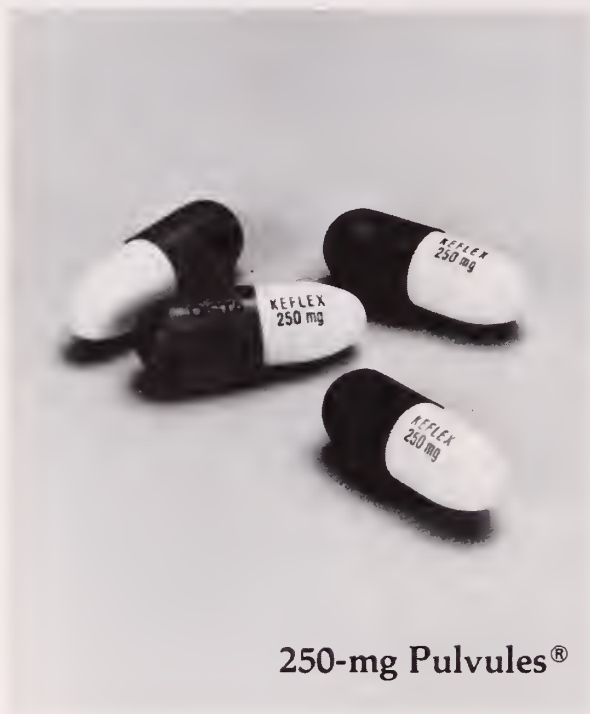
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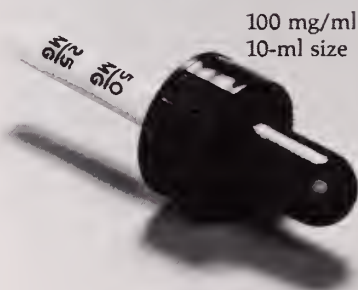


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Oklahoma State Medical Association

JULY, 1983

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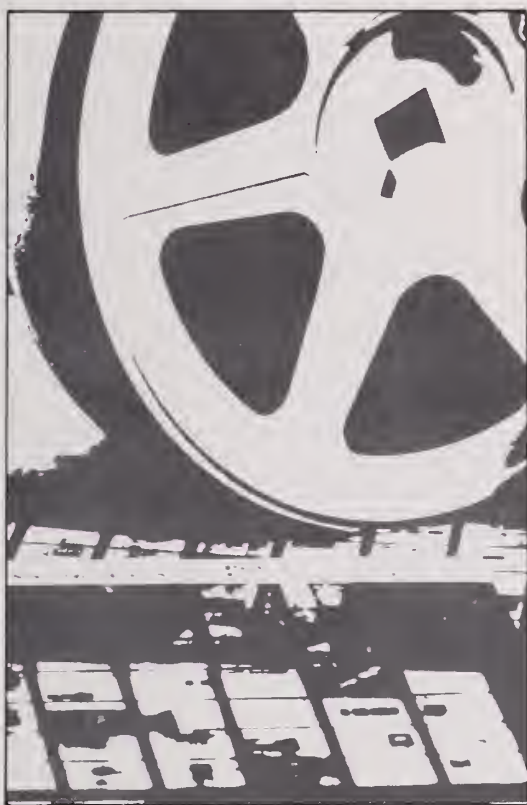


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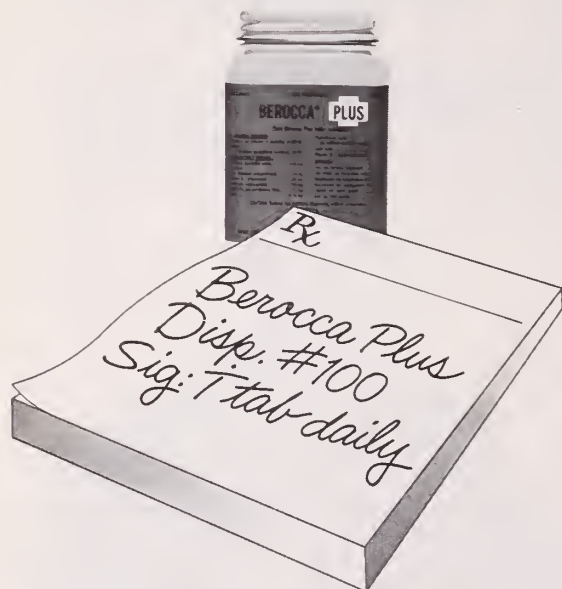


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ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

HOW SUPPLIED: Golden yellow, capsule-shaped tablets—bottles of 100.

References

1. Stone PH, Turz ZG, Muller JE. Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982.
2. Anilman E, Muller J, Goldberg S, et al. Nifedipine therapy for coronary-artery spasm: Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980.

BRIEF SUMMARY

PROCARDIA[®] (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation; 2) angina or coronary artery spasm provoked by ergonovine; or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antihypertensive effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy. Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antihypertensive medication. Additionally the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

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*"I have been able to do volunteer
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once again."*

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Procordia is indicated for the management of:

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- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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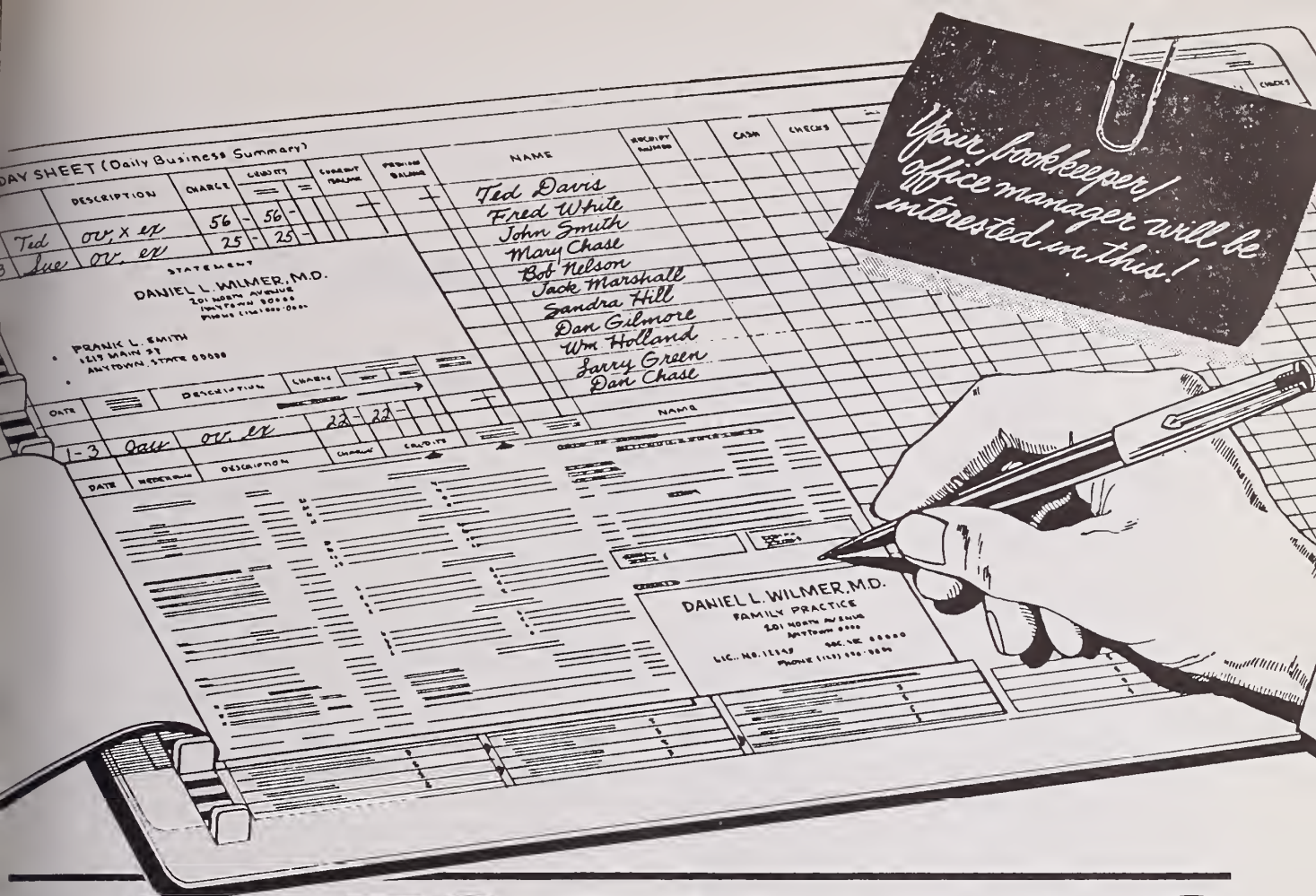
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Its incidence is greater than the aggregate incidence of all currently reportable diseases, yet it is not a reportable disease.

It cannot be contracted from a toilet seat, but it can be transmitted in rest rooms; in school rest rooms; in grade school rest rooms; by your son or daughter.

By comparison, amebiasis, typhoid fever, syphilis, and tuberculosis are benign, curable disorders. Many viral diseases and exotic pathogens are yielding to controls and subsiding in frequency while this malady is spreading with catastrophic speed.

This horrifying affliction is, of course, drug

and alcohol dependency which, as established by the persuasive facts cited above, should be categorized as a reportable communicable disease.

If the purpose of reporting communicable diseases is to alert our communities about existing threats to its health, drug and alcohol dependency should be reported.

If the purpose of reporting communicable diseases is to raise appropriate alarms, drug and alcohol dependency should be reported.

If the purpose of reporting communicable diseases is to promote the mustering of defenses, the stimulation of research, the development of cures, or the commitment of resources, drug and alcohol dependency should be reported.

If the purpose of reporting communicable diseases is to emphasize the need for new legislation, imaginative governance, and effective enforcement, drug and alcohol dependency should be reported.

Finally, if the purpose of reporting communicable diseases is to provide physicians with a means of discharging their traditional, proper, and professional obligations to their patients and their society, drug and alcohol dependency should be reported.

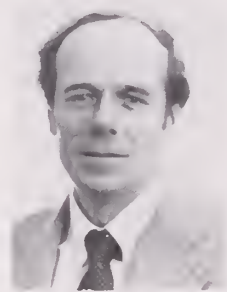
How long will we wait before making drug and alcohol dependency a reportable disease? How long *can* we wait?

—MRJ

A Boyhood Hero

Probing one's childhood roots is an experience which may give meaningful perspectives, provide welcome nostalgia, or yield unexpected twinges of pain. An exercise in endodontia of the memory, such a venture may provide pain from fibers mistakenly thought to be numb and nonconductive.

My next-door neighbor in the Arkansas hills of my own childhood was a physician. Dr Hardison came as company doctor for a lumber company, and he stayed on many years after the lumberjacks left. The mountain folk were scattered through many hills, and he never received material wealth from his medical practice. But his rewards were great. His study was an imposing mixture of medical journals, medicinal smells, and shining instruments all very impressive to my young eyes. Only later did I appreciate the irony of the foxglove blooming in his flower



garden, while his own diseased heart was strengthened by digitalis. Neither of us appreciated at the time the significance of the vinca which grew between the flagstone steps. Much later still did I appreciate the love his mountain patients had for their physician. Why else would I have been allowed to follow this gentle physician into their homes when they were ill?

His teaching reached a point of satisfaction common to all teachers when I left the Ozark hills and went on to medical school. As a student I despaired of study all too often. But I saw Dr Hardison once more. As his heart disease was in its final stages, this physician was still reading of his own disease in cardiology journals, a student inspiring me to better efforts. This physician was healer, teacher, and student.

How many of us, I wonder, were influenced in our childhood by such a complete physician? And what sort of model do we provide for those who will follow us?

George H. Kamp, M.D.

Positive Considerations of Estrogen and the Female Patient

W. CARL LINDSTROM, MD

In a recent movie the principal character managed to arouse enough of the population in his area to vocally oppose the bureaucratic mess extant. I'm mad as hell and I'm not going to take it anymore, or some similar expression.

A cartoon in some medical publication depicts two physicians, one with a medical journal in his hand saying, "How come we never see any of these diseases they write about?"

I wonder who does see the diseases and I'm damned mad about the whole misrepresented mess. The intrusion by the several bureaucracies of the federal government in their usual arrogant manner into the use or nonuse of medications and effective medical care of patients is contrary to the basics of good medical practice. Unfortunately, this approach has been aided and abetted by some members of our profession. Over the years I have been aware of the constant attack on estrogen because of its supposed carcinogenic effect.

This has only produced confusion because the expected ill effects have not been recognizable in our practice.

The trend in presenting information for public consumption, that this food, drug, drink, or atmosphere is carcinogenic, is misleading and detrimental to the proper practice of good medicine. Even though the information may be presented in some detail, practically none of the public and not all physicians interpret the presentation correctly. Few of the presentations point out that much of the information, if it is derived from studies of people at all, concerns only a fractional percentage of the population. A case in point is the apprehension and fear of carcinoma evidenced by hysterectomized women who have taken estrogen for several years, in many instances with ill effects only when they discontinue the medication. When the term cancer enters the presentation, few patients hear or recognize anything beyond that one word. I am certain this is a common observation of all physicians who work directly with patients. The constant harassment and fear-generating approach to the public and the profession concerning some form of dread disease are contrary to the very basics of good medical care.

The government and, to a large extent, the teaching side of the medical profession have taken it upon themselves to change the designations and terminology in reference to medicine. Medical industry and Health care

are deliberate changes to facilitate more control. Medicine is a personal service, not an industry. Obstetrics and gynecology is a particularly personal service. The obstetrical side of our specialty has long been involved in health care for two, not one, patients. In fact, obstetrics led the way in instituting health care. The constant and repetitive scare and alarm and harassment by the federal government and the media are in direct opposition to health care. Unneeded stress from this source can only hurt, not help.

In recent years much has appeared in the literature to indict estrogen as a carcinogen. This has not been evident in the private practice of gynecology. A statement appeared within the past two to three years pointing out that women live in a milieu of estrogen from fetal life to death and that it is inconceivable for estrogen suddenly to become carcinogenic at or near the age of the climacteric. It was hoped this observation would stimulate a more reasonable and logical approach to the use of estrogen in gynecological practice. Unfortunately, that approach has failed to materialize.

Because of the continuing attack on the use of estrogen and our "clinical impression" that the reported carcinogenic effect is not substantiated, the following report is submitted for consideration.

Our practice is a large obstetrical and gynecological private practice. Our group consists of five board certified members with a fairly diverse background of training. The introductory information is based on the observations and beliefs of the senior member of the group. The remaining members agree in principle.

Estrogen is the hormone most responsible for the development of the female. The secondary sexual characteristics are due almost entirely to the effect of estrogen. The reproductive function of the female would not be possible without estrogen. In spite of the problems that have risen and will arise from the reproductive process, I doubt that many would wish to eliminate the species.

The psychological and emotional makeup of the female is so entirely different from that of the male, estrogen must play a major part in its evolution. I realize that the thought that estrogen may be the basis for emotional and

psychological reactions will be questioned by other disciplines. Longtime observation of many women of all ages, and especially in the response of climacteric women to the administration of estrogen, makes this observation valid.

Climacteric Symptomatology

Climacteric symptoms generally have been reduced to "hot flashes" by the lay press and reinforced by published remarks from the profession. True, hot flashes are one of the most common and early symptoms of the climacteric, but not the only symptom by any means.

Symptoms of climacteric origin can be and frequently are quite devastating. Severe hot flashes, especially at night, which are accompanied by profuse sweats requiring changes of night clothing one or more times, result in inadequate rest and chronic fatigue. There are emotional and psychological changes that can be intolerable. That they are due to estrogen deprivation is readily proven by the prompt and complete reversal with adequate estrogen replacement.

Climacteric symptoms generally have been reduced to "hot flashes" by the lay press and reinforced by published remarks from the profession.

Vaginal dryness is a very common and uncomfortable climacteric-induced symptom. The basis of this symptom is vaginal atrophy, which may be associated with an actual reduction in size and capacity of the vagina and loss of any semblance of normal elasticity. Surprisingly, loss of elasticity is observed in relatively young climacteric women.

There is a recognizable reduction in sex drive associated with the climacteric. Generally, this is a temporary situation. Even so it can be very disturbing to the patient and her sexual partner. The vaginal symptoms generally are more than disturbing; they can be responsible for total inability to function sexually.

I assume that all recognize that there is no chronological limitation to sexual function. It has been my experience that the female will function sexually more adequately and much longer than the male.

All of these symptoms improve or are reversed completely with the proper administration of estrogens by either systemic or local use.

With this background of climacteric symptoms, it is rather ludicrous to categorize the symptomatology as hot flashes and ignore the broader aspects of the condition. The symptomatology and its response to estrogen therapy have been observed frequently; however, the doubters seem to be ever present. To many climacteric women, proper estrogenic therapy means the difference between living a full life and merely existing.

Views on Estrogen Use

The older texts of gynecology and obstetrics recognized the effects of estrogen and projected the great benefit to the female population if and when this substance became available for clinical use. Hardly had it become available when investigation was begun to substantiate the postulation that the substance was carcinogenic. Long years of work were begun to prove that estrogen caused breast carcinoma; to some extent, this work continues. However, endometrial carcinoma has been the target in recent years for the carcinogenicity of estrogen.

It is undeniable that without estrogen women would have neither breasts nor endometrium. In this context estrogen must contribute to the etiology of carcinomas of these organs. If the human animal were entirely eliminated there would be no problems of carcinoma of any type.

A reasonable and logical approach to the use of estrogen in gynecological medical practice must be clarified. The continued use of scare tactics concerning estrogen is detrimental to the proper medical care of women. Also, the use of this same type of information in medical education is misleading and basically dishonest. If more than one side is presented to the student, it certainly has failed to be assimilated.

It must be clear by this time that I think estrogen is being misrepresented to both the public and the profession. Estrogen is an extremely valuable tool in treating female patients, especially the climacteric population. To withhold the hormone from those women for whom it is indicated must have some chauvinistic basis. Women, after their child-bearing functions are over, continue to be valuable and contributory elements of our population and society. To deny them the equanimity and well-being that estrogen can and does produce is contrary to all basic concepts of good medical practice.

Patient Studies

For the 11-year period 1968-1978, 31,720 patients were seen by our group. During this time 87,046 examinations were done. This included obstetrical and gynecological patients. All patients are private patients from all socioeconomic levels. Caucasian, American Indian, black, and some oriental groups are represented. All patients were treated only by members of this group in a single hospital. The pathology staff of the hospital has been the same throughout the study period.

Estrogen Use Associated With Lower Death Rates in Women

A possible protective effect conferred by naturally occurring estrogen in women has often been offered as a reason why women live longer than men. In the February 18 *Journal of the American Medical Association (JAMA)*, Trudy L. Bush, PhD, and colleagues at the Oklahoma Medical Research Foundation reported that taking estrogen as a medication also appears to give users an advantage over nonusers in relative risk of death.

The researchers found that in all groups estrogen users had lower mortal-

ity rates than nonusers and that the strongest association between estrogen use and reduced risk of death was seen in women who had had the uterus and both ovaries removed. The association was weakest, although still significant, in women who were gynecologically intact.

The dependence of lower death rates on the dosage or the duration of use of estrogen cannot be assessed from the study data, Bush said, and concluded "it would be premature to alter current estrogen prescribing practices." □

In an attempt to find the usually accepted frequency of endometrial carcinoma, many interesting statistics surface. One of the older textbooks simply reports the disease as an "infrequent disease in postmenopausal women." One of the latest tests reports 20 per 100,000 population. Most reports seem to be concerned with the ratio of cervical and endometrial carcinomas to improved results of cervical carcinoma therapy. Two of the most recent papers indicate an increase in the number of endometrial carcinomas and attempt to justify the estrogenic etiology. These two articles seem to be exercises in statistical methodology and are not particularly convincing that estrogen is the carcinogen. The impression one gets is that no acceptable frequency of occurrence of endometrial carcinoma has been determined.

The older texts of gynecology and obstetrics . . . projected the great benefit to the female population if and when [estrogen] became available for clinical use.

One facet of the estrogen-carcinoma approach seems to have been resolved. Cyclic or continuous exogenous estrogen usage has no different "risk association."

Of the 31,720 patients, 1,932 were seen as obstetrical patients only. The basic patient population therefore is 29,788 patients. From this patient population between 1968 and 1978, 44 of these patients developed endometrial carcinoma. All were treated by surgery and/or radiation therapy. At the end of 1978, 41 were living and free of disease. Two patients died from conditions that had no relation to their carcinomas. One undoubtedly died from endometrial carcinoma and its metastatic complications. Her disease was diagnosed at age 58. A fourth death was probably from diabetes and cardiovascular disease; the patient was 76 when her carcinoma was diagnosed and treated only by radiotherapy.

Of the 44 patients with carcinoma, 18 had never received exogenous estrogen. Of the 26 who had received estrogen, 2 were receiving oral contraceptive pills, 1 received estrogen-androgen mixture orally, 1 received DES, 1 received estrogen parenterally, and the remainder received conjugated estrogen in doses of

0.625 mgm. and 1.25 mgm. No attempt was made to determine if the medication was given on a cyclic or on a continuous basis.

Because of our belief in continuous therapy, it is assumed all patients who received oral estrogen did so on a daily basis. The duration of the therapy varied from "occasional dose" to six years. The majority received the oral medication for two to three years.

Concerning the actual use of the medication as reported by the patient, the majority using oral estrogen will begin to experiment on reducing dosage voluntarily within the first year of use. The result of estrogenic therapy is so readily and unmistakably recognizable by the patient and her family that adequate dosage for control of symptoms becomes very simple. In fact, the patients are encouraged to adjust doses downward to arrive at minimal effective dosage. An interesting reaction of patients who become frightened by the media releases concerning carcinogenicity of estrogen has been noted: they discontinue medication but within a week resume their usual dosage with the statement that cancer risk is preferable to the distressing symptoms of the climacteric.

The patients who had endometrial carcinoma varied in age from 35 to 76.

Age Group	Number	Age Group	Number
35 - 45	7	56 - 65	13
46 - 55	15	66 - 76	9

Number of patients each year of the study:

1968	1	1972	6	1976	4
1969	1	1973	4	1977	4
1970	3	1974	7	1978	2
1971	4	1975	8		

The statistical results of the above review show a 0.15% incidence of endometrial carcinoma or 15 endometrial carcinomas per 10,000 population. It is assumed that this represents an appreciable increased frequency. However, as suggested, the incidence of disease seems to be rather vague. It must be pointed out that these same figures show that 9,985 women per 10,000 population do not develop endometrial carcinoma. Concerning the relationship of estrogen and endometrial carcinoma, the study reflects that 59% of the carcinoma cases received estrogen and 41% did not. A convincing cause and effect cannot be concluded from this.

There is no question that malignancy of any type is devastating to the patient and only slightly less so to the attending physician. Known elements of the etiology of malignancy

must, of course, be eliminated as much as possible. Harassment of the public by repeated pronouncements of possible etiological elements is neither necessary nor proper.

It should also be pointed out that in this study 93% are living and free of disease, 59% of them five years or longer.

The withholding of estrogen from the climacteric woman and the continued . . . scare tactics . . . are detrimental to the proper medical care of women.

A recent conversation with Dr Stuart Campbell of London University revealed that he feels strongly that estrogen replacement for climacteric women is a most desirable and proper treatment. He did say that unopposed estrogen therapy resulted in a large percentage of atypical adenomatous endometrial hyperplasia. This seemed to be contrary to our experience. In this time period, 297 patients were curetted for postmenopausal bleeding. Thirty-six of 297 patients had endometrial hyperplasia at D & C, and six of these had atypical hyperplasia. Forty-five percent of these 297 patients were receiving exogenous estrogen. All types of endometrium were recovered in this group, with a large percentage showing atrophic or basal endometrium.

This review clearly points out the relative infrequency of endometrial carcinoma and the good results to be expected from aggressive diagnostic procedures to ascertain the cause for vaginal bleeding in menopausal women and abnormal vaginal bleeding in climacteric women. There is no question that vaginal

bleeding can be induced in this group of women by exogenous estrogen. However, the experience reported here does not indicate an increased incidence of endometrial carcinoma from the use of exogenous estrogen.

The probable increase in number of endometrial carcinomas reported is due largely to the increased number of women and the increasing percentage of older women in the general population. No small part of this increase is due undoubtedly to the vigilance of the gynecologist in attending to what may be considered a minor type of postmenopausal vaginal bleeding and the acceptance by the female population that vaginal bleeding is not "just the change."

The withholding of estrogen from the climacteric woman and the continued harassment and scare tactics concerning its carcinogenicity are detrimental to the proper medical care of women.

My thanks and gratitude to the PAS section of Medical Records Department of St Francis Hospital and our own office force for the searching and counting that is inevitable in projects such as this.

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W. Carl Lindstrom, MD, graduated from the University of Oklahoma College of Medicine in 1934. He is a Fellow of the American College of Surgeons and the American College of Obstetrics and Gynecology.

Toxemia of Pregnancy: An Outlined Guide to Clinical Management

3. Oliguria
ml/hr.

LARRY J. D'ANGELO, MD

Toxemia of pregnancy — likened to sitting on a time bomb by many. But, the face of the timer can be seen using proper clinical tools.

I. DEFINITIONS

A. Preeclampsia — Hypertension with edema and/or proteinuria.

1. Hypertension — Diastolic B/P > 90mmHg or Systolic B/P > 140 or elevation of B/P above pre-pregnancy levels, as follows: Diastolic increased by 15mmHg or Systolic increased by 30mmHg. To be certain of diagnosis of preeclampsia these criteria must be met on two separate B/P readings separated by 6 hours with the patient at lateral bed-rest.

2. Edema — Generalized edema, not just dependent pedal edema.

3. Proteinuria — 0.5 g/l in a 24-hour urine collection or > 1 g/l (1+) in at least two random urine specimens at least 6 hours apart.

B. Severe Preeclampsia — Preeclampsia with any of the following:

1. Blood pressure Systolic > 160mmHg or Diastolic > 110mmHg (2 readings at least 6 hours apart with patient at lateral bedrest).
2. Proteinuria of > 6 gm/l in a 24-hour collection or > 3+ on qualitative examination.
3. Oliguria of < 500 ml/24 hours or < 20 ml/hr.
4. Cerebral or visual disturbances — Hypertensive encephalopathy, cerebral edema, persistent scotomata or diplopia.
5. Epigastric pain — Secondary to hepatic involvement (associated with pan-elevation of Liver Function Tests).
6. Pulmonary edema or cyanosis.
7. Evidence of Diffuse Intravascular Coagulopathy (DIC) — Thrombocytopenia is a sensitive indicator.

C. Eclampsia — Preeclampsia with the occurrence of a convulsion.

D. Chronic Hypertension — Prepregnancy hypertension or persistent hypertension beyond 6 weeks post partum. Note: During the second trimester of pregnancy, a mean arterial pressure (Diastolic B/P + 1/3 Pulse pressure) > 90mmHg is considered hypertensive and may be an indication of chronic hypertensive disease.

E. Superimposed Preeclampsia — Development of preeclampsia in patient with chronic hypertension.

F. Gestational Hypertension — Isolated hypertension that develops during late pregnancy or during first 24 hours post partum. Safest to consider this as being a variant of preeclampsia.

NOTE: These "Textbook" definitions can serve as guidelines to diagnosis; however, they should not be considered as rigid criteria for management, due to variability in clinical presentation in cases of hypertensive diseases in pregnancy.

II. MANAGEMENT

Dependent upon degree of severity vs gestational age at development of clinical disease.

A. Preeclampsia

1. During labor.

a. $MgSO_4$ IV administration — 4 gm IV push in a 10% solution (loading dose) followed by 2 gm per hour IV infusion (in 1-2% $MgSO_4$ solution). Decrease infusion rate in face of oliguria; increase rate to 3 gms per hour in face of hyperreflexia; discontinue infusion if deep tendon reflexes absent.

b. Electronic intrapartum fetal monitoring.

c. Antihypertensives — not required unless patient meets blood pressure criteria of severe preeclampsia (Diastolic > 110).

d. Diuretics — *Contraindicated*.

2. Antepartum

a. Preterm — Attempt to prolong gestation without jeopardizing mother or fetus.

Bedrest

Phenobarbital — to promote bedrest; not effective in eclampsia prophylaxis; 30-60 mg poq 4-6 hrs.

Follow for evidence of advancement to severe preeclampsia (by definitions above). One of the most sensitive parameters for following severity of preeclampsia is serial Hemotocrit; evidence of hemoconcentration generally precedes severe preeclampsia. Dropping serial creatinine clearance determination may also be helpful in this regard.

Antepartum Fetal Monitoring — twice weekly nonstress testing, Oxytocin challenge testing if nonstress test non-reactive.

Antihypertensives — not required unless Diastolic B/P > 110 (see severe preeclampsia below).

Diuretics — *Contraindicated*.

If labor begins, do not attempt to stop.

Amniocentesis — in anticipation of labor, induction, or repeat Cesarean Section; amniocentesis may show fetal lung maturity as early as 35-36 weeks gestation or earlier.

b. Term Gestation — Definitive treatment of preeclampsia is delivery. However, attempted induction in unfavorable circumstances may result in patient exhaustion with worsening clinical picture and/or commitment to Cesarean Section. May follow as with "preterm" above and attempt induction (post amniocentesis) when cervix is favorable.

B. Severe Preeclampsia

1. During Labor

a. Same as Preeclampsia (not severe) except for possible need for antihypertensive therapy.

b. Antihypertensive Therapy: Indicated for Diastolic B/P > 110mmHg; treatment of choice is parenteral Apresoline; suggest Apresoline 10 mg IM q 1 hour for Diastolic > 110 with maximum of three doses; if unresponsive then IV infusion with 0.04% solution at 10 mg/hr.

Larry J. D'Angelo, MD, is currently Associate Professor and Director of Maternal-Fetal Medicine at Tulsa Medical College and St Francis Hospital. He is a member of the Society of Perinatal Obstetricians and a Fellow of the American College of Obstetrics and Gynecology. Dr D'Angelo graduated from Emory University School of Medicine in 1971.

2. Antepartum — Generally, severe preeclampsia is an indication for delivery; however, certain selected cases may be appropriate for prolongation of gestation until fetal maturity can be achieved. Any attempt to do so should be performed only in a tertiary care center. Contraindications for continuation of gestation are as follows:
 - a. Thrombocytopenia
 - b. Pan-elevation of liver function tests (SGOT, LDH, and Alkaline Phosphatase).
 - c. Cerebral symptoms
 - d. Cardiopulmonary dysfunction
 - e. Oliguria after cautious hydration (may precipitate pulmonary edema).
 - f. Abruption Placenta
 - g. Fetal compromise — nonreactive nonstress test and positive Oxytocin challenge test.
 - h. Fetal Maturity — Amniocentesis will often reflect accelerated lung maturation, (especially in the presence of Intrauterine Fetal Growth Retardation).

Any of the above is an indication for immediate implementation toward delivery (route of delivery dictated by existing findings, ie, individualized upon obstetric indications. *Warning:* Check for thrombocytopenia before

starting a Cesarean Section.

C. Eclampsia — Termination of pregnancy always indicated, proceed as follows:

1. Stop seizure activity — $MgSO_4$, generally sufficient (as outlined above), may uncommonly require IV Valium for "status" seizures (10 mg IV slow push). *Warning:* Allow patient to regain consciousness (ie, stabilization) before attempting to accomplish delivery.
2. Prevent subsequent seizures — $MgSO_4$ infusion as outlined above.
3. Fetal evaluation by electronic monitoring.
4. Antihypertensives — Apresoline for Diastolic $> 110\text{mmHg}$ (as above).
5. Diuretics — *Contraindicated.*
6. Delivery — Route of delivery indicated by existing obstetric indications.

Warning: Check for Thrombocytopenia prior to beginning Cesarean Section. Additionally, note: High $MgSO_4$ levels may inhibit uterine responsiveness to pitocin. May require higher than usual pitocin infusion rates; therefore care must be used not to use high total doses of pitocin with large amounts of free water due to risks for hyponatremia, volume overload and potential pulmonary edema.

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Infectious Syphilis

In 1939, Oklahoma was among the first states to enact a statute requiring a serological test for syphilis as part of prenatal care. The significant decrease in the incidence of syphilis in recent years may have resulted in less attention to this procedure, since there now appears to have been a return of congenital syphilis in Oklahoma.

Infectious syphilis has increased dramatically among Oklahomans in child-bearing age groups — in 1982, over 80 percent of infectious cases were among persons between 15 and 35 years of age. Between 1975 and 1981, only four cases of congenital syphilis were reported in Oklahoma; however, this same number of cases has been reported in just the past 16 months.

The most recent case was a 9-week-old infant who was brought to medical attention for evaluation of a macular rash and bloody stools. Evaluation revealed hepatosplenomegaly, leucocytosis, hyprochloremia, hyponatremia, and a severe anemia with a hemaglobin of slightly over 3 gms. The VDRL was reactive to 64 dilutions. The infant was placed on a res-



News From
The Oklahoma State
Department of
Health

pirator and given exchange transfusions along with syphilis therapy. Despite the critical nature of the illness upon admission to the hospital, a 10-day course of penicillin therapy and other measures resulted in vast improvement. The infant was able to return home with his parents, both of whom had been treated for syphilis also.

Investigation revealed that the mother's physician had obtained the legally required prenatal serology, which was reported as negative. Since the serology at the time of delivery is discretionary on the part of the physician, it was not done. The primary lesion had appeared on the mother's genitals some three weeks prior to labor and delivery and was no longer present at the time she entered the hospital for delivery. A serological test would have been positive, however. Had this been done, the newborn infant could have been treated in time to prevent the illness. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR APRIL 1983

DISEASE	APRIL	APRIL	MARCH	TOTAL TO DATE	
	1983	1982	1983	1983	1982
Amebiasis	2	2	2	4	5
Aseptic Meningitis	9	8	5	28	18
Brucellosis	2	2	—	2	3
Encephalitis, Infectious	3	3	1	7	8
Gonorrhea (Use Form ODH-228)	1,254	1,240	1,434	5,310	5,134
Hepatitis A	48	75	31	142	205
Hepatitis B	21	30	29	82	82
Hepatitis Unspecified	21	18	28	91	79
Malaria	1	—	3	6	—
Measles (Rubeola)	—	—	—	—	—
Meningococcal Infections	4	1	5	17	9
Pertussis	12	—	3	20	2
Rabies (Animal)	17	29	12	42	78
Rocky Mountain Spotted Fever	6	3	—	6	3
Rubella	—	1	—	—	2
Salmonellosis	31	22	21	130	57
Shigellosis	24	15	8	44	98
Syphilis (Use Form ODH-228)	32	19	20	98	65
Tetanus	—	—	—	—	—
Tuberculosis	38	28	16	97	119
Tularemia	4	1	—	4	2
Typhoid Fever	1	—	—	1	2

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In Memoriam

1982

<i>A. A. Walker, MD</i>	<i>July</i>
<i>Wesley Russell Mote, MD</i>	<i>July 24</i>
<i>Thomas H. Fair, MD</i>	<i>August 15</i>
<i>Clyde E. Harris, MD</i>	<i>September 1</i>
<i>Tillman A. Ragan, MD</i>	<i>September 5</i>
<i>Floyd T. Hubbard, MD</i>	<i>September 23</i>
<i>William A. Eastland, MD</i>	<i>October 3</i>
<i>William J. Craig, MD</i>	<i>October 19</i>
<i>William M. Wood, MD</i>	<i>October 30</i>
<i>Hugh C. Graham, Sr, MD</i>	<i>November 11</i>
<i>John David Wilson, MD</i>	<i>November 11</i>
<i>Clinton Gallaher, MD</i>	<i>November 15</i>
<i>Bert F. Keltz, MD</i>	<i>November 30</i>
<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

<i>Dewey K. Rhea, MD</i>	<i>January 3</i>
<i>Fred C. Buffington, MD</i>	<i>January 4</i>
<i>C. D. Cunningham, MD</i>	<i>January 26</i>
<i>William S. Jacobs, MD</i>	<i>February 9</i>
<i>John R. Little, MD</i>	<i>February 11</i>
<i>L. A. S. Johnston, MD</i>	<i>February 16</i>
<i>Selwyn A. Willis, MD</i>	<i>March 3</i>
<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
<i>George M. Adams, MD</i>	<i>May 3</i>



Deaths

GEORGE M. ADAMS, MD 1916 - 1983

George M. Adams, MD, Tulsa anesthesiologist, died May 3 in Tulsa. Dr Adams, a native of Hominy, moved to Tulsa in 1947, where he practiced until his retirement in 1970. Dr Adams received his degree from the University of Oklahoma School of Medicine in 1943 and served in the US Navy during World War II. The OSMA awarded him a Life Membership in 1976, and in 1979 he was named Doctor of the Year by the Women's Auxiliary of the Tulsa County Medical Society.

Book Review

Medical Mycology. 3rd Edition. By Chester W. Emmons, Chapman H. Binford, John P. Utz, and K. J. Kwon-Chung. Philadelphia: Lea and Febiger, Publishers, 1977. Pp 592, Illustrated, Price \$19.50.

This is the third edition of a book on mycology written by eminent mycologists. The book is well written, quite readable, has a logical sequence, and is useful to the reader who is not well acquainted with the field of medical mycology. Several new chapters have been added and old chapters have been revised. In general, the format is the same as that in previous editions. It continues to have an appendix on culture media, diagnostic material and methods, and histopathologic procedure and special stains for fungi. It remains a basic reference book for all medical mycologists.

Harris D. Riley, Jr, MD

Miscellaneous Advertisements

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FOR SALE: Bennett IPPB therapy unit; office size motorized suction machine and treatment table (Sklar Co.); hydraulic treatment chair with Ritter unit; operating lamp, model 400; heat lamp; eye, ear, nose, and throat office instruments; water sterilizer and Beltone Audiometer. Contact J. Morgan Bush, MD, 713 Sugar Maple St., Ponca City, OK 74601. (405) 765-3466.

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MEDICINE ON THE MOVE

TECHNOLOGY & TRENDS '83



OKLAHOMA STATE MEDICAL ASSOCIATION
ANNUAL MEETING / MAY 4-7, 1983 / TULSA EXCELSIOR

HIGHLIGHTS

OSMA 1983-1984 OFFICERS AND AMA DELEGATES

The OSMA House of Delegates and Board of Trustees elected the following officers to serve the association during 1983-1984:

President—George H. Kamp, MD, Tulsa

President-Elect—James B. Eskridge III, MD, Oklahoma City

Vice-President—Elvin M. Amen, MD, Bartlesville

Secretary-Treasurer—Raymond L. Cornelison, Jr, MD, Midwest City

Speaker of the House — Larry L. Long, MD, Oklahoma City

Vice-Speaker of the House—Robert G. Perryman, MD, Tulsa

Chairman of the Board of Trustees — Michael J. Haugh, MD, Tulsa

Vice-Chairman of the Board of Trustees — Kenneth W. Whittington, MD, Bethany

Elected to serve as the association's fifth delegate to the American Medical Association (AMA) was Victor L. Robards, Jr, MD, Tulsa. Dr Robards, who had served as an



alternate delegate, fills a newly created delegate position allotted to OSMA as a result of an increase in membership. James B. Pitts, MD, Oklahoma City, was elected to the alternate delegate position.

Replacing Dr Robards as an alternate delegate is John A. McIntyre, MD, Enid, immediate past president of OSMA. Reelected as AMA delegates were James B. Eskridge III, MD, Oklahoma City, and Ed L. Calhoon, MD, Beaver. □

Above right: Dr Larry Long, speaker of the OSMA House of Delegates, calls for the next item on the agenda at the closing session of the house.



Right: Teller Dr John Phillips collects ballots from delegates voting on elective offices at the closing session of the House of Delegates.

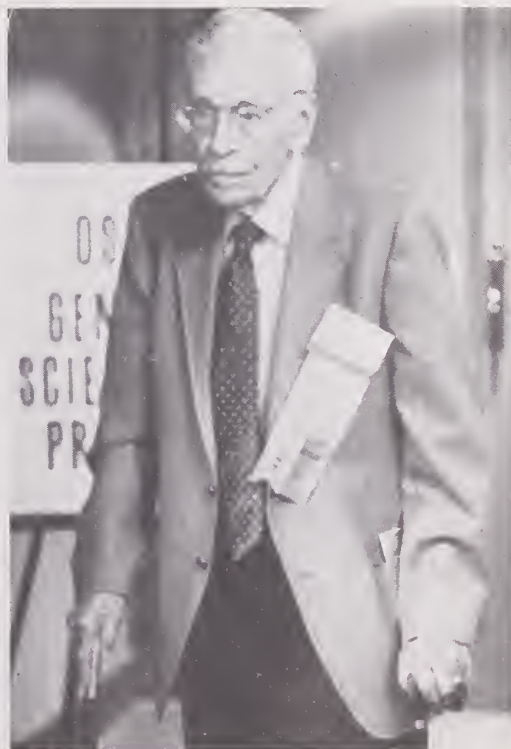


Right: Dr John McIntyre (left), outgoing OSMA president, presents a commemorative pin to Dr Kent Braden, outgoing chairman of the OSMA Board of Trustees, in recognition of Dr Braden's service to the association.

PHOTOS BY ANITA DELAPORTE AND
VIEWPOINT PRODUCTIONS, INC.

LIFE MEMBERS

Eleven Oklahoma physicians were elected to Life Membership in the Oklahoma State Medical Association by the association's Board of Trustees at the annual meeting. New Life Members are: James K. Boyd, MD, Tulsa; J. S. Chandler, MD, Muskogee; B. C. Chatham, MD, Chickasha; Edward T. Cook, Jr, MD, Anadarko; W. J. Dowling, MD, Bristow; William M. Haynes, MD, Henryetta; William E. Jones, Jr, MD, Bristow; E. C. Lindley, MD, E. H. Lindley, MD, and Robert H. Mayes, MD, Duncan; and Gilbert Tracy, MD, Okmulgee. □



Right: OSMA Life Member and Past President Dr George Garrison leaves the meeting room where the scientific sessions of the annual meeting were held.

MEDICINE ON THE MOVE

Far right: Jeanne Robertson, guest speaker at the presidential banquet, entertains the audience with a humorous solo on the ukelele. OSMA members agreed that her presentation was the highlight of the evening.



Near right: Ed Kelsay, OSMA general counsel, displays the western bronze sculpture he won in the raffle drawing at the presidential banquet.



Right: OSMA Life Members and their wives enjoy the evening's entertainment at the presidential gala. Special invitations to the banquet went to all Life Members.

Right: Incoming OSMA President Dr George Kamp (center) quiets the applauding crowd at the presidential ball. Dr John McIntyre (left) and Mrs Carol Kamp join in the applause.



Below: Dr Frank Jirka, president of the American Medical Association, attended several annual meeting functions and addressed the opening session of the House of Delegates.



PHOTO CONTEST

The OSMA 1983 Photo Contest drew more than 100 entries from member physicians and their spouses. Photographs were judged by three professional photographers, and cash prizes were awarded to the winning contestants.

Joyce Doran, Broken Arrow, took top honors, winning "Best of Show" and first and third place in the color category. Second place in the color category went to Judy Hamilton, Edmond.

In the black-and-white category, Ray V. McIntyre, MD, Kingfisher, won first place. William S. Harrison, MD, Chickasha, took second place, and William C. Stone, MD, Tulsa, was awarded third place.

Honorable mention went to four photographers: Robert L. Alexander, Jr, MD, Okmulgee; Charla Runkel, Norman; Judy Hamilton; and David Brinker, MD, Oklahoma City. □

MEDICINE ON THE MOVE

Right: Renee and Thomas Tinker, medical students at the University of Oklahoma College of Medicine, accept the Charlotte S. Leebron Memorial Trust Award from Dr. William Leebron. The Tinkers were honored for their study of nutritional habits published in the *OSMA Journal*.



Below: Dr. Jodie Edge and Mrs. Betty Edge, outgoing president of the OSMA Auxiliary, share an amusing moment at the presidential banquet head table.

EXHIBITORS VARIED

More than 20 exhibitors were present at this year's annual meeting, offering a variety of products and services to visitors. Located in the corridor to the ballroom, exhibitors appealed to physicians'

business, professional, and leisure interests with an array of samples, exhibits, and information. Exhibitors included: Air Force Medical Recruiting American Association of Medical Assistants, Inc.

Bolen Imports

Budget Computer Systems, Inc.

Ciba Pharmaceutical Company

Delta X-Ray Company

Electronic Dictation Systems, Inc.

C. L. Frates & Company

Glaxco, Inc.

Hoechst-Roussel Pharmaceuticals, Inc.

IBM

Lederle Laboratories

Merck Sharp & Dohme

Metroplex Medical & Surgical Supply, Inc.

Moore Business Systems

Oklahoma Cancer Information Line

Oklahoma Medical Political Action Committee

Oklahoma State Society of Ophthalmologists

P & F Business Forms

Schering Labs

Siggi Grimm Motors, Inc.

T. K. Smith Company, Inc.

Southwest Business Systems, Inc.

E. R. Squibb & Sons, Inc.

The Upjohn Company

Xerox Corporation



Right: Magician Sandy Rhodes and his assistant amaze the audience with their levitation act at the "Night Under the Big Top" circus show.



Right: Dr Mary Anne McCaffree laughs at the antics of "E.T.," who showed up unannounced at the "Big Top" reception.



Right: Dr Kenneth Whittington helps entertain the circus show crowd by volunteering to lose his head. Dr Whittington is the new vice-chairman of the OSMA Board of Trustees.



Right: Dr Elvin Amen, newly elected OSMA vice-president, makes a point about a proposed resolution to members of a reference committee.



Right: Dr James Eskridge and Dr Elaine Davis discuss business during a break in the meeting program. Dr Eskridge is the new president-elect of OSMA.



SPORTS SPOTLIGHT

Featured sports events at this year's annual meeting included golf and tennis tournaments and a ten-kilometer competitive run.

In the golf tournament, low gross winners were Lawrence Silvey, MD, Bethany, first place, and Robert Jabour, MD, Tulsa,

second place. Low net winners were Loren Miller, MD, Tulsa, first place, and Howard Bennett, MD, Bartlesville, second place. George Brown, MD, McAlester, had the longest drive, and William Hicks, MD, Tulsa, was closest to the pin.

In the tennis tournament, first place honors in the singles competition went to David Harper, MD, Tulsa, and second place went to Raymond Zekauskas, MD, Tulsa. Dr Harper and Dr Zekauskas joined forces to take first place in the doubles competition. Second place winners in the doubles competition were Chester Beam, MD, Oklahoma City, and Larry Killebrew, MD, Edmond.

Winners of the ten-kilometer run were: David Pillow, MD, Tulsa, overall best time and first place, 35-39 year age group; Doug Wilsey, MD, Okmulgee, first place, 30-34 years; Don Nelson, MD, Tulsa, first place, 40-44 years; Ray Maguire, MD, Tulsa, first place, 45-49 years; and Roger Paul, MD, Tulsa, first place, 50-54 years. Second place winners were P. F. Caulfield, MD, Tulsa, 35-39 year age group, and John Drake, MD, Oklahoma City, 50-54 years. □



Right: Runners in the OSMA competitive run check their watches as the race begins. The run was one of several sports events held during the annual meeting.

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REMARKS OF THE PRESIDENT-ELECT to the OSMA House of Delegates

Mr Speaker, members of the House of Delegates, and guests:

This Annual Meeting of the Oklahoma State Medical Association marks the end of my term of office as your president, an honor for which I continue to be most grateful. The honor of serving this association has enriched my life both personally and professionally, and I wish to thank you for this opportunity and for the support you have given me in this position. My detailed report of the year's activities has been presented to the Board of Trustees and will be considered in Reference Committee I for your approval. It is not necessary at this time to reiterate the various items of that report. Instead, I would like to share with you some of my thoughts and ideas which have come to impress me most during this year.



Outstanding among these is my realization of the excellence of our executive staff. David Bickham, Lyle Kelsey, Rick Ernest, Anita Delaporte, and Ed Kelsay are truly phenomenal people, and give an outstanding performance for the association. They are all instant self-starters, intelligent and creative, and they know the answers or will soon find them out. Each of them is truly a specialist in his own field, and constantly amazing in his grasp and understanding of facts, persons, and events influencing decision making by your association. Words really cannot express my appreciation to each of them for their help and support.

Your association has dealt with state and federal government representatives on many occasions during this year, and the eternal fight to protect our patients from bureaucratic suppression of quality medical care, and to preserve the freedom of the medical profession, continues unabated. The close liaison between our association and key persons in the Oklahoma State Legislature, the Federal Congress (particularly the Oklahoma Congressional Delegation), the American Medical Association

officials and staff, and with our Washington office, has kept us in close awareness of legislative activities concerning our interests. Frequently this has enabled us to impress our views upon people in government, and thus to favorably influence the formulation of policies and regulations. This, however, is a battle which will never end, and we must continue to monitor all legislative and bureaucratic activities closely, and develop greater ability to effectively influence the course of action. Every member of OSMA should be willing and eager to give of his time and talents to preserve quality care and medical freedom. The activities of OMPAC are an essential and influential mode of action, in which we all may join effectively. I urge your continued and increased support of this organization.

You are all familiar with the economic woes of the Department of Human Services, and I will not belabor those facts. The ramifications of the funding cuts, now imminent, encroach deeply into the effectiveness of the Medicaid program, medical education, health manpower, and many other programs of DHS which affect the provision and maintenance of quality medical care. OSMA has had effective input to the deliberations in progress seeking the best and most equitable solution to preserving the excellence of our medical education, our Medicaid program and indigent care, neonatal care, etc, and ways to accomplish this which are compatible with the economic crunch now present. We have constantly emphasized the necessity of maintaining quality of care, and mainstream care, as our first priority as a professional organization. Several position papers have been formulated to this end. Although we are fully cognizant of the realities of today's economy, the dilution of the quality and accessibility of care must be avoided. Solutions to these many thorny issues will be slow in coming, and certainly will not be reached in the near future. They require our continued diligent surveillance and action to reach their most desirable fruition.

I would like to digress a moment to comment on our esteemed colleague, Armond Start, MD, who is leaving our state for greener pastures.

Armond is currently Secretary-Treasurer of the OSMA, a member of the Board of Directors and Treasurer of the Physicians Liability Insurance Company, and Medical Director of the Oklahoma Foundation for Peer Review. He has rendered invaluable service to all these OSMA activities, and has been a vocative exponent of all the principles of our organization through the years. I sincerely regret his departure, but we wish you well, Armond — and I'm sorry you wouldn't accept my offer to triple your salary!

Several times during the early part of this year I was asked what my objectives were for the OSMA. Rather facetiously, my reply was — to keep out of trouble. And the first thing that happened was the Penn Square Bank failure! The Constitution of the OSMA states that the purpose of the association is to promote the science and art of medicine. Such a goal requires action to ensure that our members have the best opportunity by education, training, environment, principles, ethics, laws and regulations, and the scientific technical knowledge to provide the highest quality of care, under the greatest possible freedom of choice to provide that care. Certainly, this is a broad definition, but it has been my continuing project for the association throughout the year.

Increasing communication, increasing technology, and increasing availability and utilization of medical education enables today's Doctor of Medicine to provide the best quality care to more people in the United States than has ever been possible anywhere in the world, at any time. Economic, governmental, and demographic factors have forced organized medicine, and the OSMA, into the forum and arena of politics in order to promote and foster the science and art of medicine. In truth, all the day-to-day and year-to-year activity of OSMA is devoted to this intent. We are accused of having abandoned our search to improve the science and art of medicine and to have descended into the marketplace to scream and haggle over the dollar. I do not believe this, nor do I know any true physicians who practice it. I am still young enough to believe that nearly all physicians practice medicine for the love of their profession and patients, rather than for the money return, and that service remains the key word to describe the professional.

We are now in a social and economic climate where cost control and containment, and the fostering of competition, are the overt directives from those controlling the entitlement purse, with private enterprise adopting much

the same attitude. American business enterprises have reached the point where economic factors force them to stop paying for cost-shifting in hospital payments, and to adopt a very forceful posture of demanding, and getting, more control over medical care costs. With such converging attitudes, contracts, rules and regulations, the brunt of this attack is received by the patient, whose quality of care and access to care is immediately reduced, or whose participation in mainstream medical care is diverted to the sloughs of inadequate, nontechnical, and perhaps nonhumane paramedical help. Rapid and significant changes in the practice of medicine are occurring, with increasing momentum, which is affecting and will continue to affect our lives and our medical practice for many years. Efforts to change this course of events significantly, such as the AMA Health Policy Agenda, may take years to bear fruit, and must be supplemented by our individual and societal efforts to secure the aid of hospitals, insurance companies, business managers, and labor unions to help us maintain quality care for our patients. We must manifest at all times our individual and association aims of promoting the science and art of medicine to the best interests of our patients and of our profession.

I do not intend this to be a pessimistic report. Rather, my intent is to emphasize to you the imminent changes and rapidly developing problems facing us as practitioners of medicine, and as organized medicine, and to alert you to the opportunity, NOW, to develop and bring about the promotion of the science and art of medicine. I have unbounded faith and confidence in the integrity, intelligence, and perseverance of our individual members and the OSMA, and an upsurge of these same feelings regarding the AMA. We can and will meet this challenge. Our guest, Dr Frank Jirka, President-Elect of the AMA, exemplifies these fine qualities to an uncommon degree. We are most pleased at your election and upcoming presidency, Dr Jirka, and thank you for attending the OSMA Annual Meeting.

Dr George Kamp, I am proud to present to you an organization which is very much alive and well, and you might say "kicking," which will support you to the utmost in your coming term of office, and which I know will benefit from your leadership and wisdom during the coming year.

Thank you all, very much!

—John A. McIntyre, MD

REMARKS OF THE PRESIDENT to the OSMA House of Delegates

Mr Speaker, members of the House of Delegates, and guests:

It is a great pleasure and honor to follow John McIntyre as the President of the Oklahoma State Medical Association. Dr McIntyre's year as president of our association has certainly been one of the most challenging and most successful in our history. He has been faced by unexpected crises of major proportions in many areas. The well-known Penn Square Bank failure, the changes at the Department of Human Services, the changes in the medical schools and physician population, and the appearance of several alternative health care delivery systems are but a few of the problems John has faced. We have been fortunate indeed to have a president with his strength and experience to lead us in such difficult times.



The elections in this House this afternoon are, I think, another manifestation of the health of our association. It is indeed a sign of strength to have such able physicians as candidates for office.

Additionally, the resolutions which you will now debate and vote on are another sign of vigor. I have the greatest faith in the wisdom of this House of Delegates. We have an experienced and knowledgeable Board, a willing auxiliary, an influential delegation to the AMA, and a staff of highest quality. However, our strength is in this House of Delegates.

We have heard inspiring messages from several doctors this session of the House. Dr Jirka's speech was superb. Dr Start's sincere comments were most meaningful.

I am excited about the coming year. I am honored to be your President and I hope I have stopped talking before you have stopped listening.

—George H. Kamp, MD

Proceedings of the 77th Annual Session of the House of Delegates of the Oklahoma State Medical Association

OPENING SESSION

I. CALL TO ORDER AND OPENING REMARKS:

The House of Delegates convened its 77th Annual Session in the Excelsior Hotel, Tulsa, Oklahoma, on May 5, 1983. The Speaker, Larry L. Long, MD, Oklahoma City, called the meeting to order at 10:05 AM.

II. INVOCATION:

The invocation was delivered by John A. McIntyre, MD, Enid, President.

III. CREDENTIALS COMMITTEE REPORT:

Burdge F. Green, MD, Stilwell, Chairman of the Credentials Committee, announced that a quorum was present.

IV. ANNOUNCEMENTS:

Dr Long introduced those at the head table: Kent Braden, MD, Chairman of the Board of Trustees; Robert G. Perryman, MD, Vice-Speaker; David Bickham, Executive Director; John A. McIntyre, MD, President; Floyd F. Miller, MD, Parliamentarian; George H. Kamp, MD, President-Elect; and Susan Meeks, Recording Secretary.

Dr Long appointed the following committees to assist in the conduct of the meeting:

PARLIAMENTARIAN

Floyd F. Miller, MD, Tulsa

CREDENTIALS COMMITTEE

Burdge F. Green, MD, Chairman, Stilwell
John A. Blaschke, MD, Oklahoma City
Bruce C. Stoesser, MD, Tulsa

TELLERS

Elaine N. Davis, MD, Chairperson, Enid
William S. Harrison, MD, Chickasha
Gary W. Rahe, MD, Oklahoma City

SERGEANTS-AT-ARMS

George M. Brown, Jr, MD, Chairman, McAlester
Robert J. Weedn, MD, Duncan
Edward K. Norfleet, MD, Tulsa

REFERENCE COMMITTEE I

William O. Coleman, MD, Chairman, Oklahoma City
Edward W. Allensworth, MD, Vinita
Rheba L. Edwards, MD, Norman
Norman L. Dunitz, MD, Tulsa
Charles M. Harvey, MD, Oklahoma City
Victor L. Rogosa, MD, Alva
Oliver H. Patterson, MD, Sapulpa
Marion K. Ledbetter, MD, Tulsa

REFERENCE COMMITTEE II

John R. Alexander, MD, Chairman, Tulsa
Robert Dix, MD, Lawton
William H. Oehlert, MD, Oklahoma City
Tim K. Smalley, MD, Stillwater
Eric L. Westerman, MD, Tulsa
Richard E. Jones, MD, Shawnee
Frank K. Buster, MD, Cheyenne
Raymond L. Cornelison, Jr, MD, Midwest City

REFERENCE COMMITTEE III

Thomas C. Alexander, MD, Chairman, Okmulgee
Chester L. Bynum, MD, Norman
Kenneth L. Evans, MD, Shattuck
John D. Hastings, MD, Tulsa
S. Fulton Tompkins, MD, Oklahoma City
Carl H. Guild, MD, Bartlesville
James V. Miller, MD, Ardmore
James A. Cox, MD, Oklahoma City

Dr Long noted that Dr Tom C. Alexander would chair Reference Committee III in lieu of Dr Gary G. Evans, MD, Muskogee, whose name was included on the list in the handbooks.

News / PROCEEDINGS

Dr Long announced that late information would be distributed and also assigned to a reference committee. He noted the reference committees will meet this afternoon at 2:00 PM, and any member of the association may speak at any of the reference committees he so chooses.

Dr Long also announced that the OSMA headquarters office is in room 1510. He asked that everyone please wear his OSMA badge, as guards have been instructed that admittance to any official function requires a badge.

Dr Long announced that elections will be the first order of business when the House convenes on Saturday. The PLICO Shareholders meeting will follow the election phase, and the PLICO Forum will be held at 3:00 PM.

Dr Long recognized the following AAMA members and thanked them for their time and effort during this year's annual meeting: Ms Bonnie Glover, Tulsa; Ms Pat Crosier, CMA, Tulsa; Ms Terri Tolbert, Tulsa; Ms Betty DeLong, Oklahoma City, AAMA National Trustee; Ms Ann Strobridge, CMAAC, Oklahoma City; Ms Rita Cunningham, Oklahoma AAMA President, Bartlesville; Ms Jane Devine, CMAA, Tulsa; Ms Willena Baker, CMA, Tulsa; and Ms Kay Adams, CMA, Tulsa.

V. APPROVAL OF THE MINUTES OF THE 1982 ANNUAL MEETING:

It was moved that the House accept the minutes of the 1982 annual meeting. The motion

VI. INTRODUCTION OF SPECIAL GUESTS:

Dr Long recognized Dr John McIntyre, who introduced Frank J. Jirka, Jr, MD, President-Elect of the AMA. Dr McIntyre noted that Dr Jirka serves on the Governor's Committee on Employment of the Handicapped and is a Clinical Associate Professor in Urology at Loyola University Stritch School of Medicine. Dr Jirka was chosen President-Elect in June 1982.

Dr Jirka discussed the physician surplus dilemma and noted a projection of 70,000 surplus physicians in 1990. He also commented on the rising cost of health care and mentioned activities the AMA is involved in to improve the situation, ie, the Health Policy Agenda.

Dr Jirka stressed the critical importance of state unification and of the role of organized medicine as it pertains to future health care delivery in our country.

Dr Long thanked Dr Jirka for his comments. —Dr Long at this time introduced Rayburne W. Goen, Sr, MD, Tulsa, Chairman of the 1983 Annual Meeting.—

VII. AUXILIARY REPORT:

Dr Long recognized Mrs Betty Edge, Auxiliary President, who presented her report, which is included and made a part of these minutes. She announced that at this time \$1,020 has been raised on the raffle for "Buffalo Dreamer." She expressed thanks to everyone, and especially to Louise Martin and Cathy Young for their courteous assistance during the year. She then introduced Mrs Betty Payne, President of the National AMA Auxiliary.

Mrs Payne commended the Oklahoma auxiliary for its high accomplishments, and noted with pride that Oklahoma has the distinction of having the first organized auxiliary in the nation.

Mrs Payne noted the national auxiliary has 80,000 members. She thanked the Oklahoma physicians for their support and encouraged them to continue their support in the future.

Mrs Edge then introduced Mrs Martha Hughes, President of the Southern Medical Association Auxiliary. She then introduced Mrs Camille Harrison, incoming OSMAA President. Mrs Edge then recognized Mrs Maureen Bynum, Oklahoma State Chairman of the AMA-ERF, who presented the AMA-ERF fund checks. A check in the amount of \$24,481.30 was presented to Perry A. Lambird, MD, for the University of Oklahoma Medical College, Oklahoma City. A check in the amount of \$443.34 was presented to Edward J. Tomsovic, MD, Dean of the University of Oklahoma Tulsa Medical College. A check in the amount of \$193.33 was presented to Marion K. Ledbetter, MD, for Oral Roberts University in Tulsa.

VIII. REPORT OF THE PRESIDENT:

Dr Long presented Mrs Katie McIntyre, First Lady, with a gift. Dr Long then recognized Dr John McIntyre, President, who presented his report. (A copy of Dr McIntyre's remarks may be found on page 188 of this *Journal*.)

IX. RECESS:

The House recessed for 10 minutes to allow the county medical societies to caucus for trustee nominations. The House then reconvened at 11:25 AM.

X. NOMINATIONS FOR ELECTIONS:

Dr Long declared the House open for nominations for the position of President-Elect (one-year term of office). *James B. Eskridge III, MD*, Oklahoma City, was nominated by Perry A. Lambird, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Vice-President (one-year term of office).

Elvin M. Amen, MD, Bartlesville, was nominated by H. E. Denyer, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Delegate to the AMA (Position I).

Ed L. Calhoon, MD, Beaver, was nominated by William M. Leebron, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Delegate to the AMA (Position V).

Orange M. Welborn, MD, Ada, was nominated by Clarence P. Taylor, Jr, MD. *The nomination was seconded.*

Victor L. Robards, Jr, MD, Tulsa, was nominated by John R. Alexander, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Alternate Delegate to the AMA (Position I).

James B. Eskridge III, MD, Oklahoma City, was nominated by James D. Funnell, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Alternate Delegate to the AMA (Position V).

James B. Pitts, Jr, MD, Oklahoma City, was nominated by James B. Eskridge III, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of Secretary-Treasurer (two-year term of office).

Raymond L. Cornelison, Jr, MD, Midwest City, was nominated by Thomas N. Lynn, Jr, MD. *The nomination was seconded twice.*

Edward K. Norfleet, MD, Tulsa, was nominated by Rayburne W. Goen, Sr, MD. *The nomination was seconded.*

There being no other nominations, the nominations were declared closed.

Nominations were declared open for Trustee and Alternate Trustee for the following Trustee Districts (three-year term of office):

DISTRICT VI.

Reporting on the caucus of representatives from District VI, the following nominations were made:

James D. Funnell, MD, Oklahoma City, and *Kenneth W. Whittington, MD*, Bethany, were nominated for the positions of Trustee. *The nominations were seconded.*

Perry A. Lambird, MD, Oklahoma City, and *Raymond L. Cornelison, Jr, MD*, Midwest City, were nominated for the positions of Alternate Trustee. *The nominations were seconded.*

DISTRICT VII.

Jodie L. Edge, MD, Norman, was nominated for the position of Trustee. *The nomination was seconded.*

Eldon V. Gibson, MD, Shawnee, was nominated for the position of Alternate Trustee. *The nomination was seconded.*

DISTRICT VIII.

John R. Alexander, MD, Tulsa, and *Michael J. Haugh, MD*, Tulsa, were nominated for the positions of Trustee. *The nominations were seconded.*

Edward K. Norfleet, MD, Tulsa, and *Donald F. Mauritson, MD*, Tulsa, were nominated for the positions of Alternate Trustee. *The nominations were seconded.*

DISTRICT IX.

W. Kermit Baker II, MD, Muskogee, was nominated for the position of Trustee. *The nomination was seconded.*

Thomas C. Alexander, MD, Okmulgee, was nominated for the position of Alternate Trustee. *The nomination was seconded.*

DISTRICT X.

Robert K. Jackson, MD, McAlester, was nominated for the position of Trustee. *The nomination was seconded.*

R. L. Winters, MD, Poteau, was nominated for the position of Alternate Trustee. *The nomination was seconded.*

XI. REPORT OF THE CHAIRMAN OF THE BOARD OF TRUSTEES:

Dr Kent Braden noted this report will be forwarded to the appropriate reference committee, and it is among the handbook materials available for this meeting. He announced that the new board Chairman for 1983-84 is Michael J. Haugh, MD, Tulsa, and the Vice-Chairman is Kenneth W. Whittington, MD, Bethany.

XII. REPORT OF THE SECRETARY-TREASURER:

Dr Armond Start referred the House to his report included in the handbooks and commented on the information. He expressed his appreciation for the OSMA members' quick response to the cash flow problem by sending in dues in a timely manner. He explained that the total assets of the association are \$5 million, and of those assets about \$3.5 million is invested in PLICO. Dr Start noted that despite the Penn Square Bank incident, the OSMA's financial picture is quite healthy.

Dr Start indicated he plans to comment on the 1983 budget during the reference committee hearing, and anyone is welcome to come and discuss it with him during that time.

Dr Start presented the membership report and noted that the total number of OSMA members is currently 3,682 with 187 memberships pending at this time.

Dr Start then addressed the House and made the following points:

- He is proud of the OSMA for founding PLICO, which has grown in assets from \$1.5 million to \$24 million in three years.
- He applauded the OSMA Medicare Project, and commended Oklahoma physicians for addressing the problems involved in Medicare.
- He urged the members to join the 200 Club of OMPAC and stressed the importance of physicians remaining unified in this country. The Oklahoma Delegation has a significant impact on the AMA and in Washington.
- The Oklahoma prison health care system has greatly improved, now having nine full-time licensed physicians and two full-time psychiatrists.
- The Oklahoma Foundation for Peer Review is controlled by the physicians. Dr Start urged all physicians to support the

OFPR. He further stressed the importance of medical records documentation and urged physicians to stop admitting patients to the hospital who could be treated on an outpatient basis.

Dr Long thanked Dr Start for his remarks.

XIII. PRESENTATION OF BUSINESS TO BE BROUGHT BEFORE THE HOUSE OF DELEGATES:

Dr Lambird noted that the Oklahoma County Medical Society was opposed to Resolution 5, which deals with eliminating the mandatory AMA membership requirement.

XIV. OTHER BUSINESS:

None was presented at this time.

XV. NECROLOGY REPORT:

Robert G. Perryman, MD, Vice-Speaker, read the Necrology Report. (A copy of the report is attached and made a part of these minutes.)

*NECROLOGY REPORT
1982-83*

George M. Adams, MD
Harold T. Baugh, MD
Berget H. Blocksom, MD
John A. Brasfield, MD
Fred C. Buffington, MD
William J. Craig, MD
C. D. Cunningham, MD
William A. Eastland, MD
Thomas H. Fair, MD
Virgil Ray Forester, MD
Clinton Gallaher, MD
Hugh C. Graham, Sr, MD
Clyde E. Harris, MD
Floyd T. Hubbard, MD
William S. Jacobs, MD
L. A. S. Johnston, MD
Bert F. Keltz, MD
John R. Little, MD
Wesley Russell Mote, MD
Holice B. Powell, MD
Tillman A. Ragan, MD
Dewey K. Rhea, MD
George Ross, MD
A. A. Walker, MD
Loyd G. Williams, MD
Selwyn A. Willis, MD
John David Wilson, MD
William N. Wood, MD

XVI. ADJOURNMENT:

The Opening Session of the House of Delegates was adjourned at 12:35 PM.

CLOSING SESSION

I. CALL TO ORDER AND OPENING REMARKS:

The Closing Session of the 77th Annual Meeting of the House of Delegates was called to order by Speaker Larry L. Long, MD, Oklahoma City, at 1:10 PM in the Manchester/Geneva Room of the Tulsa Excelsior Hotel.

II. INVOCATION:

The invocation was delivered by Mrs Betty Edge, outgoing President of the OSMA Auxiliary.

Dr Long appointed John W. Phillips, Jr, MD, Tulsa, to serve as an additional Teller.

III. REPORT OF THE CREDENTIALS COMMITTEE:

Credentials Committee Chairman Burdge F. Green, MD, Stilwell, announced that a quorum of Delegates was present.

IV. ELECTION OF OFFICERS:

Dr Long noted that there are two contested races for election this year, and from one of the races a vacancy will occur for one of the AMA Alternate Delegate positions.

There being no dissent as to the non-contested positions, Dr Long declared that the following nominees be elected:

James B. Eskridge III, MD, Oklahoma City — President-Elect

Elvin M. Amen, MD, Bartlesville — Vice-President

Ed L. Calhoon, MD, Beaver — AMA Delegate (Position I)

James B. Eskridge III, MD, Oklahoma City — AMA Alternate Delegate (Position I)

James B. Pitts, Jr, MD, Oklahoma City — AMA Alternate Delegate (Position V)

James D. Funnell, MD, Oklahoma City — Trustee, District VI

Kenneth W. Whittington, MD, Bethany — Trustee, District VI

Perry A. Lambird, MD, Oklahoma City — Alternate Trustee, District VI

Raymond L. Cornelison, Jr, MD, Midwest City — Alternate Trustee, District VI.

Jodie L. Edge, MD, Norman — Trustee, District VII

Eldon V. Gibson, MD, Shawnee — Alternate Trustee, District VII

John R. Alexander, MD, Tulsa — Trustee, District VIII

Michael J. Haugh, MD, Tulsa — Trustee, District VIII

Edward K. Norfleet, MD, Tulsa — Alternate Trustee, District VIII

Donald F. Mauritsen, MD, Tulsa — Alternate Trustee, District VIII

W. Kermit Baker II, MD, Muskogee — Trustee, District IX

Thomas C. Alexander, MD, Okmulgee — Alternate Trustee, District IX

Robert K. Jackson, MD, McAlester — Trustee, District X

R. L. Winters, MD, Poteau — Alternate Trustee, District X.

The following positions were elected by ballot later in the meeting as the results were tallied:

Raymond L. Cornelison, Jr, MD, Midwest City — Secretary-Treasurer.

Victor L. Robards, Jr, MD, Tulsa — AMA Delegate (Position V)

The election of Dr Robards to this AMA Delegate position left a vacancy for AMA Alternate Delegate position IV. Dr Long stated that it is written in the OSMA Bylaws in Chapter VI, Section 6, that the President may appoint someone to fill the vacancy. Dr McIntyre noted that, with this being an unusual circumstance, he would prefer that this be done by a vote of the House.

It was moved that Chapter VI, Section 6 of the OSMA Bylaws be set aside in order to allow the House to vote on this issue. The motion was seconded and carried. Dr Long declared the House open for nominations.

John A. McIntyre, MD, Enid, was nominated by Joseph W. Stafford, MD, Enid. *The nomination was seconded.*

Michael J. Haugh, MD, Tulsa, was nominated by Norman L. Dunitz, MD, Tulsa. *The nomination was seconded.*

It was moved that nominations cease. The motion was seconded and carried.

The vote was taken by ballot and then tallied.

John A. McIntyre, MD, Enid, was elected AMA Alternate Delegate (Position IV).

The following nominees for Board of Directors for PLICO, as submitted by the OSMA

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Nominating Committee (Board of Trustees Report D) by acclamation:

Ed L. Calhoon, MD, Beaver
Billy R. Goetzinger, MD, Oklahoma City
Floyd F. Miller, MD, Tulsa
Ray V. McIntyre, MD, Kingfisher

Dr Long explained that the Board of Trustees had decided to expand the size of the PLICO Board, from 15 to 18 by adding three Advisory Members. The Advisory Members had all the privileges of a Director except for voting. In its Board of Trustees Report D, the Nominating Committee had recommended the following individuals for the three Advisory Member positions:

Billy Dale Dotter, MD, Okeene
Victor L. Robards, Jr, MD, Tulsa
Kenneth W. Whittington, MD, Bethany

Dr Robards asked that *James J. Snipes, MD*, Tulsa, be nominated in his stead.

Dr Joseph W. Stafford, MD, Enid, nominated *David M. Selby, MD*, Enid, for PLICO Advisory Member.

The following were elected by ballot for the positions of Advisory Members to the PLICO Board of Directors:

Billy Dale Dotter, MD, Okeene
David M. Selby, MD, Enid
Kenneth W. Whittington, MD, Bethany

V. ANNUAL PLICO SHAREHOLDERS MEETING:

Dr C. Alton Brown, MD, Oklahoma City, President and Chairman of the PLICO Board, presented his report at this time. (A copy of his report is attached and made a part of these minutes, and may be found on page 222 of this *Journal*.)

Dr Brown made mention of the PLICO Board Members and the PLICO Advisory Members nominations. Their names and the outcome are recorded in the election phase of these minutes.

VI. PRESENTATION OF AWARDS:

Dr John A. McIntyre presented Dr Kent Braden with the Past Chairman of the Board of Trustees pin. Dr Braden then expressed his thanks.

Dr William M. Leebron, MD, Elk City, presented the Charlotte S. Leebron Memorial Trust Fund Award of \$500 to Thomas V. Tinker, MSIII, and Renee Ann Tinker, MSIII, Oklahoma City, for the most worthy paper published in the *Journal* for 1982-83. Their ar-

ticle, "An Analysis of Nutritional Knowledge in the General Public," was published in the September 1982 issue of the *Journal*, Vol. 75, No. 9.

On behalf of the Editorial Board of the *Journal* of the Oklahoma State Medical Association, Dr Leebron also presented the Tinkers with the Sandoz Pharmaceutical Award of \$100 as runner-up for this same outstanding paper.

The Tinkers expressed their thanks.

VII. REMARKS OF THE PRESIDENT-ELECT:

George H. Kamp, MD, incoming OSMA President for 1983-84, presented a brief report, which was distributed afterwards to the House. (A copy of Dr Kamp's remarks may be found on page 190 of this *Journal*.)

COMMEMORATIVE RESOLUTIONS:

Dr James B. Pitts, Jr, Oklahoma City, introduced a resolution commemorating Dr Armond H. Start, Oklahoma City, for his numerous contributions to Oklahoma medicine, and for his outstanding job as Medical Director of the Oklahoma State Department of Corrections.

Dr Elaine N. Davis, Enid, presented a resolution commemorating James A. Merrill, MD, Oklahoma City, for his outstanding service and many contributions to doctors and patients in Oklahoma, through the practice of gynecology and obstetrics.

Dr John A. McIntyre, Enid, introduced a resolution commemorating Mrs Louise Martin, Editorial Assistant, for her 26 years of devoted service to the Oklahoma State Medical Association.

The above noted resolutions were adopted by the House. These commemorative resolutions are included as a part of these minutes. (They may be found on page 282 of this *Journal*.)

VIII. REFERENCE COMMITTEE REPORTS:

Dr Long stated the Reference Committee reports would be governed by Roberts Rules of Order. A Delegate may speak once for or against a question. Variation from that will be at the Chair's discretion. He asked that each Delegate state his name and county medical society when speaking before the House. Dr Long stated that a recommendation by a Reference Committee is automatically introduced as a motion and does not require a second.

The Reference Committee reports considered by the House are attached and made a part of these minutes.

Report of
REFERENCE COMMITTEE I:

Presented by William O. Coleman, MD, Oklahoma City.

Reference Committee I approved the following items without amendment:

Item 1. Report of the Board of Trustees:

The Reference Committee commended the Board on its diligence and especially commended Kent Braden, MD, Chairman, and Michael J. Haugh, MD, Vice-Chairman.

Item 2. Supplemental Report of the Board of Trustees.

Item 3. Board of Trustees Report A — Penn Square Bank.

Item 4. Board of Trustees Report C — ERF.

Item 5. Report of the Physicians Liability Insurance Company.

Item 8. Report of the Secretary-Treasurer and the Budget and Audit Committee Report:

The Reference Committee expressed its sincere appreciation to Dr Armond H. Start for his years of devoted service as Secretary-Treasurer of the OSMA, and particularly commended him in his efforts in averting the potentially disastrous financial crisis faced after the Penn Square Bank failure.

Item 9. Report of the Council on Long Range Planning and Development.

Item 10. Report of the Constitution and Bylaws Committee.

Item 11. Report of the Financial Aid to Education Committee.

Reference Committee I approved the following items as amended:

Item 5A. Board of Trustees Report D — Nominees for PLICO Board of Directors:

It was noted that the Reference Committee did not consider this item. The election of nominees submitted by the OSMA Nominating Committee is detailed in the election phase of the minutes. (Report D is made a part of these official minutes and may be found in this *Journal* on page 209.)

Items 6 and 7. Resolution 4 — Non-Discriminatory Health Care Reimbursement — and Resolution 15 — Outpatient Psychiatric Coverage:

The Reference Committee recommended the following substitute resolution be adopted in lieu of Resolutions 4 and 15:

Resolved, That the House of Delegates hereby recommend that the Board of Directors of PLICO modify its PLICO health policy to include coverage for outpatient psychiatric services rendered by psychiatrists.

After some discussion there was a call for division, and a vote by show of hands. The motion failed, by a vote of 59 no's to 33 aye's, and the resolution was therefore rejected by the House.

Item 13. Resolution 10 — OSMA and Multiple Proposals to Restructure Medical Care Delivery System into Competing Economic Units:

The Reference Committee recommended that the following substitute resolution be adopted in lieu of Resolution 10:

Resolved, That the OSMA establish an Ad Hoc Committee under the Council on Medical Services to begin immediately to study and to provide information to its physician members in the following areas:

- a) Legal questions for Oklahoma physicians to engage in contractual agreements with provider organizations;
- b) Aspects concerning contracting one's professional services to a provider group and at the same time provide professional services to non-group individuals;
- c) Relationships among competing provider economic groups, eg, competing hospital based groups, entrepreneur groups, or church related groups, keeping in mind that extensive discounting of fees for services will be rampant;
- d) Should the OSMA establish a brokerage information service for its members to provide information analysis, negotiating assistance and other services to physicians considering contracts for their services.

After considerable discussion on this item, it was moved that this item be referred to the Board of Trustees for disposition. The motion was seconded and carried.

Item 14. Resolution 17 — Chelation Therapy:

The Reference Committee offered the following comment in regard to this resolution:

Mr Speaker, this resolution was discussed at length, and your Reference Committee

recommends that all members of the Association be urged to contact their state senators immediately to recommend that they vote against House Bill 1394, which would make it mandatory for any insurance company writing health insurance in Oklahoma to cover without question chelation therapy.

Dr M. Boyd Shook, Oklahoma City, stressed the urgency of this situation, that this bill will go directly to the Senate floor, without debate, for final approval.

The Reference Committee recommended that the following resolution be adopted in lieu of Resolution 17:

Resolved, That the Oklahoma Delegation to the AMA be encouraged to request that the Council on Scientific Affairs or the appropriate council, committee, or authority of the American Medical Association study the indications, efficacy, safety, and potential benefits and risks of chelation therapy, and that a report be submitted to the House of Delegates and state and county societies as soon as possible.

After some discussion, it was moved that the following amendment be added to the main motion (above substitute resolution):

; and, be it further

Resolved, That the Council on Professional and Public Relations begin with all due speed to inform the public regarding the potential and actual side effects of this therapy.

The motion to amend the main motion was seconded and carried. It was then moved that the main motion as amended be approved. This motion was seconded and carried.

Reference Committee I rejected the following item:

Item 12. Resolution 5 — Mandatory AMA Dues.

It was moved to adopt the Report of Reference Committee I as a whole. The motion was seconded and carried.

*Report of
REFERENCE COMMITTEE II:*

Presented by John R. Alexander, MD, Tulsa
Reference Committee II approved the following items without amendment:

Item 1. Board of Trustees Report B — Cancer Research Project.

Item 2. Report of the Council on Professional and Public Relations:

The Reference Committee commended the Council on its fine job in carrying out its duties during the past year.

Item 3. Report of the President:

The Reference Committee expressed its sincere appreciation for Dr John A. McIntyre's exceptional leadership and direction throughout the past year.

Item 4. Report of the Council on Public and Mental Health:

The Reference Committee commended the Council on a job well done.

Item 5. Report of the Council on Medical Education:

The Reference Committee expressed its appreciation for the manner in which the Council carried out its activities.

Item 6. Council on Medical Education Report A—Health Manpower Surveillance Committee.

Item 7. Report of the Council on Member Services:

The Reference Committee expressed its appreciation for the Council's fine work it has performed this year.

Item 8. Report of the OSMA Auxiliary:

The Reference Committee commended Mrs Betty Edge for her outstanding dedication and leadership.

Item 9. Report of the Oklahoma Foundation for Peer Review.

Item 10. Report of *The Journal of the Oklahoma State Medical Association*:

The Reference Committee extended its gratitude to Mrs Louise Martin for her many years of dedicated service to the OSMA Journal.

Item 11. Report of the Perinatal Task Force:

Drs Hal B. Vorse and Mary Anne McCaffree, both of Oklahoma City, expressed their appreciation for the OSMA's support concerning this task force.

Item 12. Resolution 1 — JCAH.

Item 17. Resolution 14 — Perinatal Intensive Care.

Item 18. Resolution 18 — Peer and Fee Review.

Reference Committee II approved the following items as amended:

Item 13. Resolution 2 — Nuclear War.

The Reference Committee recommended that the following substitute resolution be adopted in lieu of Resolution 2:

Resolved, That the Oklahoma State Medical Association supports in concept the edu-

cation of physicians regarding the medical aspects of nuclear injury.

The motion to approve the substitute resolution was seconded. After some discussion a vote was taken, and the motion carried.

Item 14. Resolution 6 — Indigent Patient Care:

The Reference Committee recommended that Resolution 6 be adopted with the following addition:

; and, be it further

Resolved, That the content and intent of this resolution be made public through proper channels at the appropriate time.

The motion was seconded and carried.

Item 15. Resolution 11 — Medical Education in Nutrition:

The Reference Committee recommended that Resolution 11 be adopted with the following amendments:

Delete the last word on line 4 through and including all of line 8 and add to the end of line 4 "therefore, be it" and further delete the word "seriously" in line 10 and the words "or all" in line 11.

Item 16. Resolution 12 — Horseback Riding Safety:

The Reference Committee recommended adoption of Resolution 12 with the following word change:

The last word in line 20 "require" be deleted and the word "encourage" be inserted.

This motion was seconded.

It was then moved and seconded that the word "require" be kept rather than replaced. This motion failed.

The main motion was brought to a question and the motion carried.

It was moved that the House adopt the Report of Reference Committee II as a whole. The motion was seconded and carried.

Report of
REFERENCE COMMITTEE III:

Presented by Thomas C. Alexander, MD, Okmulgee

Reference Committee III approved the following items without amendment:

Item 1. Report of the Council on Governmental Activities:

The Reference Committee commended the Council and specifically Dr Perry Lambird for the considerable amount of time devoted to the federal legislative process.

Item 2. Council on Governmental Activities Medicare Demonstration Project Report A:

The Reference Committee commended the Council and the OSMA Board of Trustees for their continuous study of this most interesting proposal. The Reference Committee recommended that this project be scrutinized, refined, and submitted to the congressional delegation for consideration, and if the program is implemented, that it include acquiring demographic baseline medical data on participants.

Item 3. Report of the Council on State Legislation:

The Reference Committee made special mention of the White Paper and commended the Council for its development. The Reference Committee especially commended Dr Bill Hughes for his effective leadership of this Council.

The Reference Committee recommended that copies of the White Paper be made available to OSMA members for use in educating their patients in the hazards of using unapproved medication and drugs.

Item 4. Senate Committee Project 89ers Report A.

Item 5. Senate Ad Hoc Committee on Medicare Report B.

Item 6. Report of the Council on Medical Services:

The Reference Committee commended the Council for a job well done.

Item 7. Medical Orders by Non-Medical Personnel Report A.

Item 8. Assignment of Insurance Benefits Report B.

Item 9. Report of the Oklahoma Medical Political Action Committee:

The Reference Committee also urged all OSMA members to join OMPAC.

Item 10. Report of the Ad Hoc Committee on Medical Malpractice:

The Reference Committee expressed appreciation to this Committee for its completed work and concurred with the recommendation that this Committee be dissolved.

Item 11. Grievance Committee Report:

The Reference Committee also suggested that when the Grievance Committee refers a case to the county society for adjudication that it also request a follow-up from the county society as to the disposition of the case, and, when necessary, that the patient

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be informed of the appeal process through OSMA.

Item 12. Physicians Committee Report.

Item 13. Maternal Mortality Committee Report.

Item 15. Resolution 7 — DRG's

Item 17. Resolution 13—Stronger Penalties for Practicing Medicine without a license.

Item 18. Resolution 16 — "Baby Doe" Rule — Mandating Care For Handicapped Infants.

Reference Committee II approved the following item as amended:

Item 14. Resolution 3 — Use of Physical Therapy Equipment by Unqualified Personnel:

The Reference Committee recommended adoption of the following substitute resolution in lieu of Resolution 3:

Resolved, That the OSMA encourage all physicians to assist in the proper usage, by authorized personnel, of all physical therapy equipment in their area of the state; and be it further

Resolved, That the OSMA House of Delegates recommend to the Council on State Legislation that the state law be strengthened that regulates the sale of physical therapy equipment and should include appropriate qualifications for those health professionals who operate such equipment.

Item 16. Resolution 8 — Key Man:

The Reference Committee recommended adoption of Resolution 8 and that it be forwarded to the AMA House of Delegates with a change in the term "Key Man" to "Key Physician."

It was moved that the House adopt the Report of Reference Committee III as a whole. The motion was seconded and carried.

IX. OTHER BUSINESS:

Dr Long expressed his thanks to all who have worked to make this annual meeting a success, and in particular to Dr Rayburne Goen, Sr, and the Annual Meeting Planning Committee. Dr Long also thanked the Tulsa doctors for hosting the meeting.

Dr Long announced there was a total of 640 registrants for the annual meeting this year.

Dr Long also announced that the Alumni Association Banquet and Ball would be held this evening in the International Ballroom; cocktail reception at 6:00 PM and dinner at 7:00 PM.

X. ADJOURNMENT:

It was moved that the Closing Session of the 77th Meeting of the House of Delegates adjourn. The motion was seconded and approved. The House of Delegates adjourned at 3:25 PM. Recorded by Toni Leverett.

Report of REFERENCE COMMITTEE I

Presented by: William O. Coleman, MD, Chairman

Mr. Speaker and Members of the House of Delegates:

Reference Committee I gave careful consideration to the several items referred to it and submits the following report:

(1) REPORT OF THE BOARD OF TRUSTEES RECOMMENDATION:

Mr. Speaker, your Reference Committee considered the Report of the Board of Trustees and would like to commend them on their diligence and especially commend Kent Braden, MD, Chairman, and Michael J. Haugh, MD, Vice-Chairman. The Reference Committee recommends that *the Report of the Board of Trustees be adopted.*

(2) SUPPLEMENTAL REPORT OF THE BOARD OF TRUSTEES RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the Supplemental Report of the Board of Trustees be adopted.*

(3) BOARD OF TRUSTEES REPORT A — PENN SQUARE BANK RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *Report A of the Board of Trustees be filed*, as it is an informational item.

(4) BOARD OF TRUSTEES REPORT C — ERF RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *Report C of the Board of Trustees be adopted.*

(5) REPORT OF THE PHYSICIANS LIABILITY INSURANCE COMPANY RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the Report of the Physicians Liability Insurance Company be adopted.*

(6) and (7) RESOLUTION 4 — NON-DISCRIMINATORY HEALTH CARE REIMBURSEMENT AND RESOLUTION 15—OUTPATIENT PSYCHIATRIC COVERAGE
RECOMMENDATION:

Mr. Speaker, both of these resolutions were discussed at length during the meeting, and your Reference Committee recommends *the following substitute resolution be adopted in lieu of Resolutions 4 and 15:*

Resolved, That the House of Delegates hereby recommend that the Board of Directors of PLICO modify its PLICO health policy to include coverage for outpatient psychiatric services rendered by psychiatrists.

(8) REPORT OF THE SECRETARY-TREASURER AND THE BUDGET AND AUDIT COMMITTEE REPORT
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the Report of the Secretary-Treasurer and the Budget and Audit Committee Report be adopted*. The Committee would also like to express its sincere appreciation to Dr Armond H. Start, for his years of devoted service as Secretary-Treasurer of the Oklahoma State Medical Association, and would particularly like to commend him in his efforts in averting the potentially disastrous financial crisis that we faced after the Penn Square Bank failure.

(9) REPORT OF THE COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the Report of the Council on Long Range Planning and Development be adopted*.

(10) REPORT OF THE CONSTITUTION AND BYLAWS COMMITTEE
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the Report of the Constitution and Bylaws Committee be filed*, as it is an informational item.

(11) REPORT OF THE FINANCIAL AID TO EDUCATION COMMITTEE
RECOMMENDATION:

Mr. Speaker, being that this is also an informational item, your Reference Committee

recommends that *the Report of the Financial Aid to Education Committee be filed*.

(12) RESOLUTION 5 — MANDATORY AMA DUES
RECOMMENDATION:

Mr. Speaker, your Reference Committee heard no testimony in support of Resolution 5, but did hear unanimous testimony in favor of unified membership; therefore, your Reference Committee recommends that *Resolution 5 not be adopted*.

(13) RESOLUTION 10 — OSMA AND MULTIPLE PROPOSALS TO RESTRUCTURE MEDICAL CARE DELIVERY SYSTEM INTO COMPETING ECONOMIC UNITS
RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that *the following substitute resolution be adopted in lieu of Resolution 10:*

Resolved, That the OSMA establish an Ad Hoc Committee under the Council on Medical Services to begin immediately to study and to provide information to its physician members in the following areas:

- a) Legal questions for Oklahoma physicians to engage in contractual agreements with provider organizations;
- (b) Aspects concerning contracting one's professional services to a provider group and at the same time provide professional services to nongroup individuals;
- c) Relationships among competing provider economic groups, eg, competing hospital-based groups or entrepreneur groups or church related groups, keeping in mind that extensive discounting of fees for services will be rampant;
- d) Should the OSMA establish a brokerage information service for its members to provide information analysis, negotiating assistance and other services to physicians considering contracts for their services.

(14) RESOLUTION 17—CHELATION THERAPY

Mr. Speaker, this resolution was discussed at length, and your Reference Committee recommends that all members of the Association be

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urged to contact their state senators immediately to recommend that they vote against House Bill 1394, which would make it mandatory for any insurance company writing health insurance in Oklahoma to cover without question chelation therapy.

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *the following resolution be adopted in lieu of Resolution 17:*

Resolved, That the Oklahoma Delegation to the AMA be encouraged to request that the Council on Scientific Affairs or the appropriate council, committee, or authority of the American Medical Association study the indications, efficacy, safety, and potential benefits and risks of chelation therapy and that a report be submitted to the House of Delegates and state and county societies as soon as possible.

Mr Speaker, this concludes the Report of Reference Committee I. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,
William O. Coleman, MD, Chairman
Edward W. Allensworth, MD
Rheba L. Edwards, MD
Norman L. Dunitz, MD
Charles M. Harvey, MD
Victor L. Rogosa, MD
Oliver H. Patterson, MD
Marion K. Ledbetter, MD
Ed Kelsay, Staff
Toni K. Leverett, Staff

Report of the BOARD OF TRUSTEES

SUBJECT: Annual Report

PRESENTED BY: Kent Braden, MD, Chairman

REFERRED TO: Reference Committee I

INTRODUCTION:

The Board of Trustees of the OSMA has completed three of its quarterly meetings for organizational year 1982-83. The fourth, or Annual Meeting, of the Board is being held in conjunction with this Annual Meeting of the Association. The proceedings of the Annual Board Meeting are covered in the Supplemental Report of the Board of Trustees.

During the past year the Board met on September 12 and November 21, 1982, and February 27, 1983. A quorum was certified for each meeting with an average of 27 Officers and Trustees and 6 AMA Delegates or Alternates in attendance.

PENN SQUARE BANK:

Because of the collapse of the Penn Square National Bank in July, 1982, much of the Board's time was taken up with discussions of the possible consequences.

At the time of the bankruptcy the OSMA had approximately \$700,000 on deposit at Penn Square. The deposits were all in \$100,000 certificates of deposit and were rotated and cashed in as needed to pay current bills or were re-invested. The Association was able to withdraw \$256,384 with the FDIC's approval.

At the direction of the Board, the Association studied the possibility of purchasing insurance for deposits exceeding \$100,000 in any one bank. The Board acknowledged that better interest rates were available whenever a deposit greater than \$100,000 could be made. Negotiations were begun with Lloyds of London for such coverage. In the meantime the Association reexamined its investment policy and some funds were moved in order to stay within the \$100,000 FDIC coverage limit.

During the November meeting the Treasurer reported that there was still \$440,000 in Penn Square Bank for which the Association was holding an FDIC Certificate of Deposit. The treasurer explained that because of the amount of money tied up, there was a possibility of a cash flow problem near the end of December 1982, but that he did not anticipate this occurring and that it did not appear the OSMA would need to borrow funds. (In fact, the cash flow problem did not develop. Most county medical societies, knowing that the Association might have a possible cash flow problem, made extraordinary efforts to collect their 1983 annual dues and many of them were paid in completely before the end of the year.)

At the February meeting it was announced to the Board of Trustees that the auditors were predicting that probably as much as 50% of the funds tied up in Penn Square Bank could be recovered. It was also reported to the Board at the February meeting that there was a possibility that at least a partial payment of recovered funds would be made in the first quarter of 1983.

Even with the Penn Square disaster, the Association's Treasurer, Armond H. Start, MD,

reported to the Board at the February meeting that the Association was in excellent financial condition and that it had not been necessary to borrow funds to fill out the 1982 year.

PLICO:

The Association's wholly-owned professional liability insurance company, PLICO, was the subject of discussion at each of the Board meetings. PLICO's two divisions . . . professional liability and PLICO Health . . . report separately to the House of Delegates.

PLICO was also involved in the Penn Square Bank collapse. During the November meeting of the Board, C. Alton Brown, MD, Chairman of the PLICO Board, reported that PLICO had approximately \$800,000 on deposit in Penn Square and had been able to recover \$200,000, leaving a balance of approximately \$600,000 for which it had received FDIC certificates. When compared with the company's reserves well in excess of \$10 million, the potential loss from Penn Square, although tragic, would not affect the financial condition of the company in any material way.

Dr Brown also reported that the PLICO Board of Directors had approved the discontinuation of all additional charges over and above the premium for professional liability coverage. Specifically, the PLICO Board had approved the discontinuation of the capitalization assessments and policy fees. The assessments have been collected from OSMA members insured through PLICO for three years and the policy fees had been collected from non-members for the same period of time. Their purpose was to create a capital fund of approximately \$4 million for PLICO. Dr Brown told the OSMA Board that the reason for the recommendation to discontinue the assessment and policy fee was first that the full amount of capitalization had been accomplished and, second, there had been a reduction in overhead and management costs and, third, when this was combined with PLICO's constant vigil to defend all nonmeritorious cases, rather than settle them, there was no real need to continue either program.

The OSMA Board of Trustees, after considerable discussion, voted separately to discontinue the assessment fee for OSMA members and then to discontinue the policy fee for non-OSMA members. At the same time, however, the Board authorized the PLICO Board to reinstitute the policy fee for nonmembers if such should become appropriate.

During the February meeting this year, the OSMA Board of Trustees amended the PLICO Bylaws to limit service on the PLICO Board of Directors to two consecutive terms of three years each. In addition, the Board called for the creation of 3 advisory member positions on the PLICO Board. (State Insurance law specifies that an insurance company Board of Directors cannot exceed 15, the present number on the PLICO Board. Thus the 3 new positions are "advisory.")

The OSMA Board of Trustees, also at the February meeting, voted to instruct the PLICO Board of Directors to select a special committee to re-study the payment of outpatient services for psychiatrists under the PLICO Health Plan. The motion also contained a request that the PLICO Board report back to the OSMA Board about the reconsideration.

HEALTH SCIENCES CENTER:

During the past year, with the retirement of Lloyd Rader as Director of the State Welfare Department and the decreasing sales tax income to the Department, much discussion revolved around the possibility of taking Oklahoma Memorial Hospital, Children's Hospital, and the O'Donoghue Rehabilitation Center, all located at the Health Sciences Center, out from under the jurisdiction of the Department of Human Services. Great concern was expressed that the legislature might begin to break the Department of Human Services (Welfare Department) into smaller units without giving due consideration to the funding for the institutions located on the Health Sciences campus.

During its September meeting, the Board of Trustees adopted a formal statement on the University Hospitals that said, in pertinent part, "OSMA recognizes the need to relieve the Department of Human Services of a portion of its financial burden. But since no existing agency or Board appears to meet the . . . (management and funding criteria outlined) . . . we recommend that the hospitals not be immediately or precipitously separated from the Department. We propose that an ongoing and thoughtful study be undertaken to explore fully the alternatives available for managing and financing the hospitals."

ENDOWMENT FUND:

In May of 1982 the House of Delegates of the OSMA voted to designate the funds that had previously been contributed to a professorship

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in continuing medical education to a diabetes professorship. This was conditional on the ability to match the funds dollar per dollar. Dr C. Alton Brown reported to the Board that he felt confident that the matching funds could be raised . . . having already collected over \$55,000 in cash plus a \$20,000 pledge.

The Board then voted to deposit the funds in an appropriate bank and to create a committee to oversee and manage the fund. The committee was to be comprised of the OSMA President each year, Dr C. Alton Brown as a permanent member, and the section chief of the section on endocrinology at the Health Sciences Center.

FOUNDATION FOR PEER REVIEW:

The Oklahoma Foundation for Peer Review reported to the September 12 meeting of the Board that it had undergone another evaluation by the Department of Health and Human Services and that it had received enough points to "pass."

It was also reported to the Board that the Foundation had been approached by a Tulsa group, the Tulsa Business/Health Coalition, about the possibility of the Foundation doing private review, specifically pre-admission certification for insured patients. It was reported that the coalition had not specifically asked for pre-admission certification, but that some of the companies involved had indicated they were interested in that approach.

The OSMA Board voted to inform the OFPR Board that they wish to be on record as standing firm with the OSMA House of Delegates recommendation that the original concept of the OURS program and the review being done presently be conducted, "but not to expand that to include pre-certification admission requirements."

In November it was reported that the Foundation was preparing to enter into a new contract with the Oklahoma Department of Human Services effective January 1 to continue PSRO-type review for another year.

During the February Board meeting the Foundation reported that it was making progress in negotiations with the Tulsa Business/Health Coalition regarding a contract for private review. At the same time the Foundation reported that they again were undergoing an evaluation by the Department of Health and Human Services to determine whether or not the Foundation should be

funded for PSRO or PRO purposes in the future.

1984 ANNUAL MEETING:

In September the Board reconfirmed a previous decision that the 1984 Annual Meeting be held May 9-12 at Shangri-La Lodge located on Grand Lake near Grove, Oklahoma. The staff was authorized to proceed with signing a contract with Shangri-La for the meeting space.

AMA RESOLUTIONS:

During the September meeting the Board authorized two resolutions to be forwarded to the American Medical Association for consideration by its House of Delegates at the 1982 interim meeting.

The first resolution resolved "that the American Medical Association rescind its prior endorsement of Reagan Administration economic policies."

The basis for this resolution was the feeling that the AMA's original endorsement was too broad and that the earlier action of the AMA House of Delegates could serve to "hinder or limit the American Medical Association's responses to administration . . ." economic initiatives.

The second resolution called for the expansion of the AMA's Board of Trustees by the addition of a total of 6 new members . . . "added at the rate of 2 per year for each of the 3 years following the adoption of the bylaw's amendment."

The resolution stated, "the limited number of AMA Trustees tends to produce an ever increasing reliance upon (AMA) staff for guidance . . ." and that the increasing numerical disparity between the House of Delegates of the AMA and the Board of Trustees appeared to be weakening communication to the Association's detriment.

During the November meeting the AMA delegation from Oklahoma indicated that it had introduced two additional resolutions for consideration at the interim meeting, dealing with the AMA's inability to properly respond to bills dealing with economics presented to Congress.

The Board of Trustees endorsed all four of the resolutions.

COUNCIL AND COMMITTEE REPORTS:

Customarily the Board of Trustees hears reports from all of the OSMA Councils and Committees during each meeting. Since these groups also report directly to the House of Delegates on their year's activities, their reports to the Board will not be reproduced here.

AMA/GTE PRESENTATION:

A special demonstration on a new computer concept was presented to the Board when it met in November. The American Medical Association had entered into a contract with GTE Corporation to develop a nationwide computerized informational network.

A physician, with a microcomputer in his own office, could subscribe to the electronic network and have immediate access to computerized drug information, disease information, medical procedure coding and nomenclature information, a library reference file including both socioeconomic and bibliographic information, and an electronic mailing service called Med-Mail.

This latter service would allow a physician who was on the network to correspond with any other physician on the network using his office terminal.

GTE and the AMA are working nationwide to establish distributors and implement the entire nationwide system.

FOREIGN MEDICAL GRADUATES:

Possible problems with foreign medical graduate laws were discussed at both the September and November meetings of the Board. In a special report during September's meeting, Dr Mark Johnson, MD, a member of the Oklahoma Board of Medical Examiners, reported that for the past five years there had been a significant influx of foreign medical graduates into Oklahoma. He stated that this had become an issue for two major reasons: 1) Their total almost equals the number of graduates of medical colleges in the state of Oklahoma and 2) it involves an increasing difficulty in evaluating the clinical competency of individuals and, in general, the graduates of foreign medical colleges.

Specifically, there is no proven authority to examine and evaluate foreign medical schools, and in recent years there has been proliferation of them, particularly in the Caribbean area. These are usually proprietary schools that attempt to entice American citizens who have attempted to gain entry into a US school and failed to leave the country for an education.

Many of the graduates of foreign schools, particularly Americans who have left the country for training, have great difficulty in passing the various state licensure examinations and, in many instances, the ECFMG test.

The doctor also indicated that there were problems with Oklahoma's program of award-

ing certificates for a limited institutional practice to foreign-trained physicians. It was his feeling that the Board of Medical Examiners was probably going to recommend that this alternative route to practice be eliminated. During the November meeting of the Board it was reported that the Board of Medical Examiners had in fact made plans to do away with temporary certificates.

PRESENTATION OF SPECIAL AWARDS:

The Association posthumously honored Ray C. Lytle for his 30 years as general legal counsel for the OSMA during the September meeting. Mrs Lytle was presented with a Certificate of Appreciation from the OSMA.

Dean A. McGee, Chairman of the Board of Kerr-McGee Industries, was finally presented with the 1981 Outstanding Layman's Award from the Association. Mr McGee had been very active in supporting many organizations, including AMCARE, the Oklahoma Medical Research Foundation, Presbyterian Hospital, and the McGee Eye Institute. (Mr McGee had been designated as the recipient of the Outstanding Layman's Award in 1981, but due to the press of business at that time was unable to appear.)

The 1982 Outstanding Layman's Award was also presented in the September meeting to former Oklahoma Senator Henry Bellmon.

Two A H Robins Awards were given to Oklahoma physicians during the November Board meeting. Orange M. Welborn, MD, presented the first of the two awards to Malcom E. Phelps, MD. Moments later, William M. Leeborn, MD, presented the second A H Robins Award to James B. Pitts, Jr, MD.

LIFE MEMBERSHIP AWARDS:

The following physicians have been awarded life membership in the Oklahoma State Medical Association through application from component societies and with the approval of the Association's Board of Trustees:

SEPTEMBER 12, 1982

Kieffer D. Davis, MD, Bartlesville
Eugene M. Henry, MD, Muskogee
Byron C. Hollenback, MD, Altus

NOVEMBER 21, 1982

Edward W. Bank, MD, Enid
Harry L. Dupree, MD, Santa Fe, New Mexico
Mexico
Robert P. Holt, MD, Oklahoma City
Camp S. Huntington, MD, Bartlesville
Alwyn T. Kornblee, MD, Tulsa
Otis S. Lee, MD, Tulsa
Herbert A. Masters, MD, Tahlequah

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Robert P. Messinger, MD, Oklahoma City
Waldo B. Newell, Jr, MD, Enid
George L. Norris, MD, Bartlesville
Don H. O'Donoghue, MD, Oklahoma City
Earl M. Robinson, MD, Enid
Gerald Rogers, MD, Oklahoma City
Robert M. Shepard, Jr, MD, Tulsa
Joseph J. Smith, MD, Shattuck
Dale E. Van Wormer, MD, Tulsa

FEBRUARY 27, 1983

Eugene H. Arrendell, MD, Norman
William A. Betts, MD, Tulsa
Allen B. Bunch, MD, Seminole
Ernest F. Deese, MD, Ada
Neumon D. Johnson, MD, Tulsa
Edward R. Maier, MD, Oklahoma City
Robert D. Mercer, MD, Oklahoma City
E. Cotter Murray, MD, Oklahoma City
Albert L. Shirkey, MD, Tulsa
Ralph A. Smith, MD, Oklahoma City
Phillip G. Tulos, MD, Oklahoma City
Joe E. Tyler, MD, Tulsa
Homer C. Wheeler, MD, McAlester

Respectfully submitted,
Kent Braden, MD, Chairman
OSMA Board of Trustees

Supplemental Report of THE BOARD OF TRUSTEES

SUBJECT: Supplemental report
PRESENTED BY: Kent Braden, MD, Chair-
man
REFERRED TO: Reference Committee I

Mr. Speaker and Members of the House:

The Board of Trustees met at its Annual Meeting yesterday, and this supplemental report identifies for the Delegates the actions taken for the Board at this meeting. This report will be referred to Reference Committee I to be considered along with the Annual Report of the Board which was included in the Delegate's Handbook. The board meeting was called to order by Kent Braden, MD, Chairman, at 4:10 PM with introductions of guests and announcement that this was the 77th annual meeting of the Oklahoma State Medical Association.

The board approved the minutes with one editorial change and two name additions of the February 27 board meeting.

Dr Armond H. Start, MD, Secretary-Treasurer, presented a financial report to the

board, and reported that the OSMA is in excellent financial shape.

John A. McIntyre, MD, President, gave his final report to the board as the association's highest elected official. Dr McIntyre expressed his appreciation to the board members for their assistance and encouragement throughout the year, and also thanked the OSMA staff for their outstanding work and assistance.

Dr McIntyre noted that there are two openings on the Board of Medical Examiners — Carroll E. Holsted, MD, Kingfisher, has completed his seven-year term. Three individuals were nominated for the Governor's consideration:

Ray V. McIntyre, MD, Kingfisher
Carroll E. Holsted, MD, Kingfisher
Jack D. Fetzer, MD, Woodward

Dr McIntyre also noted that Dr Phillip N. Kingery has resigned from his position, and three individuals were nominated to fill his unexpired term:

William M. Leebron, MD, Elk City
James R. Rhymer, MD, Clinton
Frank K. Buster, MD, Cheyenne

The board also approved a request by Mrs Camille Harrison, Auxiliary President-Elect, to provide \$500 plus expenses for a special speaker to come and discuss drug prevention.

After discussion the Board of Trustees instructed the staff to prepare a resolution for reference committee debate that would permit peer review and fee review. A late resolution was also introduced and accepted detailing the hazards of chelation therapy.

After some discussion, the board went on record stating that physicians should be the determining factor in the blood supply system to hospitals, and this statement will be forwarded to the Council on State Legislation for disposition.

Dr Harold M. Chandler, MD, Oklahoma City, was endorsed by the board to represent the OSMA on the 1983-84 Advisory Council to the Oklahoma Board of Nurse Registration and Nursing Education.

A resolution regarding the "Baby Doe" ruling was introduced for reference committee debate. The resolution was forwarded to the OSMA staff to be finalized and prepared for the reference committee.

The OSMA Nominating Committee has submitted several names for nominations for the available PLICO Director and PLICO Advisory Member positions. The list of names was accepted and will be distributed to the House

with the Board of Trustees Report D.

The following individuals were submitted to the board and approved for special memberships as noted:

Twilah A. Fox, MD, 1 year dues exempt membership

James K. Boyd, MD, Tulsa, life membership

J. S. Chandler, MD, Muskogee, life membership

B. C. Chatham, MD, Chickasha, life membership

Edward T. Cook, Jr, MD, Anadarko, life membership

W. J. Dowling, MD, Bristow, life membership

William M. Haynes, MD, Henryetta, life membership

William E. Jones, Jr, MD, Bristow, life membership

E. C. Lindley, MD, Duncan, life membership

E. H. Lindley, MD, Duncan, life membership

Robert H. Mayes, MD, Duncan, life membership

Gilbert Tracy, MD, Okmulgee, life membership

Special honorary memberships were awarded by the board to Wilson D. Steen, PhD, University of Oklahoma Health Sciences Center, and Mr Don Blair, Executive Vice President of PLICO, for their outstanding contributions to Oklahoma Medicine.

The Board of Trustees decided to present Outstanding Layman's Awards to two individuals this year, Mr George Short, Oklahoma City attorney, and Mr William H. Bell, Tulsa attorney.

The board also endorsed Floyd F. Miller, MD, Tulsa, as this year's recipient of the A H Robins Award.

In other action, the board:

- Approved Donald W. Bobek, MD, Tulsa, to fill a vacancy on the OFPR Board of Directors, due to the resignation of Dr Miller.

- Instructed the staff to write a letter to support of designating the Mary Mahoney Health Center in Oklahoma City as a medically underserved area.

- Approved OSMA group life insurance coverage by Continental Insurance Company.

- Approved OSMA's entering into a contract arrangement with Wisconsin Physician Services for purchase of the computer leased by the Oklahoma Foundation for Peer Review.

The Board of Trustees gave Dr Kent Braden, Chairman, and Dr Michael J. Haugh, Vice-Chairman, a standing ovation, and elected

Michael Haugh, MD, and Kenneth Whittington, MD, Bethany, as Chairman and Vice-Chairman, respectively.

The board accepted for presentation to the House of Delegates reports presented in the handbooks.

There being no further business, the board adjourned at 6:45 PM.

Report: A

SUBJECT: Penn Square Bank

PRESENTED BY: Kent Braden, MD, Chairman

REFERRED TO: Reference Committee I

INTRODUCTION:

In 1973, after reviewing the capabilities of a number of Oklahoma City banks, the Executive Committee and the Board of Trustees selected the Penn Square Bank as its principal depository. This decision was made after considering numerous factors: convenience, services, and return on investments. Prior to that time we banked with the First National Bank of Oklahoma City.

The arrangement with Penn Square permitted us to make daily deposits without going downtown or using the mail; gave us the capability of transferring by wire funds to other banks for investment purposes and for transferring AMA dues to Chicago banks; and allowed us to maximize the return on surplus deposits.

The association collects most of its annual income during the months of December, January, and February. As dues are collected, they are accumulated in the association savings account until we have enough to purchase a \$100,000 CD. We then negotiate a rate of return and a term consistent with our cash needs. We maintain contact with a number of banks who quote CD rates on a daily basis.

In addition to dues income, OSMA has dedicated funds held for specific purposes — the endowment fund for the medical school and our insurance trust funds for members enrolled in the group life program are examples. Also, OSMA had accumulated a reasonable surplus from years in which income exceeded expenses.

For the two years prior to the Penn Square Bank failure, the bank was consistently the highest bidder for the excess deposits of OSMA — generally about one percentage point more than competing banks. During 1983 the association's interest and commission income exceeded \$100,000.

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PENN SQUARE BANK DEPOSITS:

At the time the bank was declared insolvent the association's accounts at Penn Square were as follows:

Deposits

Certificates of Deposit	\$600,000.00
Accrued Interest	16,272.69
Deposit Accounts	
Membership	11,742.95
Payroll	568.50
Insurance Trust	44,872.73
Risk Management	6,317.09
Risk Management Savings	6,580.27
Travel	1,947.89
Total Deposits	<u>\$688,302.12</u>

Armond L. Start, MD, the Secretary-Treasurer and David Bickham, the Executive Director, negotiated with FDIC officials for several days after the bank was taken over. The association first argued that the deposits were in separate \$100,000 increments and were therefore insured. The FDIC rejected that position on the grounds that OSMA was a single identity and there was only one corporate account with one tax ID number, and stated the accounts would have to be merged into one account. The OSMA representatives then presented evidence showing that association monies came from different sources and for different purposes and should be considered different accounts. The FDIC officials agreed in part and made disbursements as follows:

Disbursements

Endowment	\$111,998.16
Membership	93,196.13
Group Insurance Trust	44,872.73
Risk Management	6,317.09
Total Disbursements	<u>\$256,384.11</u>

Thus the OSMA was refunded \$256,384.11 of the \$688,302.12 on deposit, and was issued a claim for the balance of \$431,918.01. On March 24, 1983, the FDIC paid the association \$73,787.72, representing a 20%* dividend to be applied against the principal owed by the bank. The bank owes OSMA a balance of \$358,130.29, not counting any interest that may be paid.

* Actually less than 20% , because the bank had overdrawn the OSMA checking account. The overdraft was deducted from the dividend.

It is still unclear about the future distribution of funds. Historically, the FDIC has done well when taking over banks, and the average payout exceeds 90% according to one official.

OSMA'S CURRENT FINANCIAL CONDITION:

Most of the money remaining in Penn Square Bank is the association's surplus funds. Projected income for 1983 is expected to again exceed expenses, and barring any unforeseen difficulties, there will be no financial crisis. Officers and staff have taken necessary steps to avoid another Penn Square incident. Surplus funds are invested in \$100,000 Certificates of Deposit whereby no single bank holds more than the insured maximum.

For a detailed review of the association's finances, delegates are referred to the Secretary-Treasurer's report and to the auditors' statement.

CONCLUSION:

This is an informational report for action as deemed necessary by the House of Delegates.

Respectfully submitted,
Kent Braden, MD, Chairman

Report: C

SUBJECT: Creation of An Education and Research Foundation

PRESENTED BY: Kent Braden, MD, Chairman

REFERRED TO: Reference Committee I

INTRODUCTION:

During its 1982 Annual Meeting the OSMA House of Delegates authorized the creation of a special medical education and research foundation for the State Medical Association. The purpose of the foundation would be to give the association a vehicle to accept donations, grants, bequeathals, and other contributions for the betterment of public health through scientific and medical research and continuing medical education.

The foundation would be established as a separate organization incorporated under the laws of the State of Oklahoma. Membership in the corporation, for control purposes, would be limited to the officers and members of the Board of Directors of the Oklahoma State Medical Association.

Once established, the foundation will seek designation as a nonprofit tax-exempt organization under Section 501(c) (3) of the Internal Revenue Code. This designation, or one similar to it, available for certain "private" foundations, would mean that any contribution to the foundation would be deductible for federal income tax purposes by the contributor.

The creation of the legal structure for an educational and research foundation is relatively easy. The State of Oklahoma puts very few restrictions on such activities, relying primarily on the requirements of the Internal Revenue Service to control foundation activities. Consequently it will be necessary for the newly formed foundation to operate for approximately two years on a temporary letter of authorization from the IRS. The service should then grant a permanent tax-exempt status.

The Association is using the American Medical Association's Education and Research Foundation Bylaws and Articles of Incorporation as a model to be followed in Oklahoma. The purposes section of the AMA-ERF Bylaws is broad enough to allow the foundation to undertake almost any activity it would like to in the way of public health information, medical research, support of medical schools and continuing education programs, and even, if it desires, financial assistance to medical students.

Once the foundation is incorporated under the laws of the State of Oklahoma and a temporary letter of tax-exempt status is received from the IRS the Association will begin to actively solicit contributions to the foundation. Following the AMA-ERF as a guide, the foundation will accept contributions to a "medical school fund" where the contributor can designate that the funds are to be transferred to a specific medical school, such as an alma mater. Unrestricted funds received will be used to help support special health and medical programs and research, and provide emergency grants for special studies.

Once created, the foundation will actively seek funds in the form of gifts of cash, gifts of real estate, gifts of securities, gifts through wills, gifts through insurance, and life income gifts. A special publication is being prepared to explain each one of the different types of gifts and how they can be transmitted to the foundation, while at the same time serve as a tax deduction advantage to the contributor.

It is presently projected that the formal "paperwork" portion of establishing the found-

ation should be completed by mid to late summer and the actual solicitation of gifts and contributions should begin in the Fall of 1983.

Respectfully submitted,
Kent Braden, MD, Chairman
OSMA Board of Trustees

Report: D

SUBJECT: Nominees for the PLICO Board of Directors

PRESENTED BY: Kent Braden, MD, Chairman

REFERRED TO: Reference Committee I

INTRODUCTION:

The House of Delegates adopted in 1980 a procedure for soliciting and selecting members of the PLICO Board of Directors. The Board of Trustees has recommended that the PLICO Board be expanded by three advisory members, and the necessary bylaw changes have been adopted to accomplish that expansion. Thus, there are four board members to be selected by the House of Delegates and three advisory members.

We have followed the procedure for soliciting nominees, and more than 60 physicians were recommended. Others may be nominated from the floor of the House.

NOMINATING COMMITTEE REPORT:

The committee recommends the following board members:

Ed L. Calhoon, MD, Beaver (incumbent)
Billy R. Goetzinger, MD, OKC (incumbent)
Floyd F. Miller, MD, Tulsa (incumbent)
Ray V. McIntyre, MD, Kingfisher (incumbent)

Advisory members:

Billy Dale Dotter, MD, Okeene
Victor L. Robards, Jr, MD, Tulsa
Kenneth W. Whittington, MD, Bethany

(For informational purposes, the recommendations are attached to this report.)

Respectfully submitted,
Kent Braden, MD, Chairman
C. Alton Brown, MD
John A. McIntyre, MD

NOMINATIONS FOR PLICO DIRECTOR

Ed L. Calhoon, MD, Beaver
Billy R. Goetzinger, MD, OKC
Floyd F. Miller, MD, Tulsa
Ray V. McIntyre, MD, Kingfisher

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NOMINATIONS FOR PLICO ADVISORY MEMBER

John R. Alexander, MD, Tulsa
Bert M. Avery, MD, Enid
William G. Bernhardt, MD, MWC
John A. Blaschke, MD, OKC
C. O. Bohlman, MD, Watonga
Barbara F. Braden, MD, Edmond
Kent Braden, MD, OKC
Donald L. Brawner, MD, Tulsa
Earl M. Bricker, Jr, MD, OKC
John W. Bumpus, MD, Bethany
John C. Chelf, MD, Enid
William O. Coleman, MD, OKC
Raymond L. Cornelison, Jr, MD, MWC
O. W. Dehart, MD, Vinita
H. E. Denyer, MD, Bartlesville
Richard G. Dotter, MD, OKC
Billy D. Dotter, MD, Okeene
John W. Drake, MD, OKC
Norman L. Dunitz, MD, Tulsa
E. Edwin Fair, MD, Ponca City
Jack D. Fetzer, MD, Woodward
Harvey L. Gaspar, MD, Tulsa
Burdge F. Green, MD, Stillwell
William S. Harrison, MD, Chickasha
Charles M. Harvey, MD, OKC
Michael J. Haugh, MD, Tulsa
Joe S. Hester, MD, Muskogee
H. Clark Hyde, MD, OKC
George H. Jennings, MD, OKC
Herbert M. Kravitz, MD, OKC
James R. Leach, MD, Tulsa
Larry L. Long, MD, OKC
Clifford L. Lorentzen, MD, Ardmore
Thomas N. Lynn, Jr, MD, OKC
John W. Marks, MD, Blackwell
Howard P. Maulden, MD, OKC
Stanley R. McCampbell, MD, OKC
Richard A. McKinne, MD, Muskogee
Jose R. Medina, MD, Tulsa
Leo Meece, MD, Woodward
James V. Miller, MD, Ardmore
H. J. Moreland, MD, Bartlesville
Arnold G. Nelson, MD, MWC
Robert G. Perryman, MD, Tulsa
James B. Pitts, Jr, MD, OKC
Alexander Poston, MD, OKC
Jerry L. Puls, MD, Tulsa
Don F. Rhinehart, MD, OKC
Victor L. Robards, Jr, MD, Tulsa
David Russell, MD, Enid
David M. Selby, MD, Enid

James J. Snipes, MD, Tulsa
Harlan Thomas, MD, Tulsa
Lanny F. Trotter, MD, Stillwater
M. C. Wagnon, MD, MWC
Orange M. Welborn, MD, Ada
Eric L. Westerman, MD, Tulsa
Kenneth W. Whittington, MD, Bethany
Charles F. Womack, MD, OKC

Report of the SECRETARY-TREASURER

SUBJECT: Annual Report
PRESENTED BY: Armond H. Start, MD,
Secretary-Treasurer
REFERRED TO: Reference Committee I

INTRODUCTION:

The financial information contained in your handbook includes the accountants' year-end report, the Budget and Audit Committee's review of the accountants' report, a balance sheet for the months of January through March, 1983, and a proposed budget for 1983-84. The failure of the Penn Square Bank was an extraordinary event, entirely unanticipated. Board of Trustees Report A details the events and impact on the association. The association still has considerable assets tied up in the bank's liquidation process (as the report states), but we are still financially sound with reasonable reserves. We did not have to borrow to finish our fiscal year, and this report does not indicate a need for a dues increase.

ACCOUNTANTS' REPORT:

The assets of the association grew only slightly last year from \$5,049,772 to \$5,064,800. This was primarily due to two reasons: 1) The PLICO assessment was completely paid in 1981 and there was no new contribution to PLICO capital structure in 1982; 2) The accountants have written off \$211,402 of our Penn Square deposits (\$73,787.72 has been collected since this report has been prepared.). The remainder of the asset section is consistent with previous years' operations, considering the PLICO and Penn Square deviations.

The liability section of the statement is likewise consistent with previous years' operations (again considering the deviations mentioned above). Deferred income represents

dues collected but not yet earned. Dues are allocated on a monthly basis.

The following calculation will provide a rough estimate of ready funds available for association activities:

Current Assets	\$757,789
Current Liabilities	\$856,025
Less Deferred Income	<u>617,935</u>
Actual Current Liabilities	<u>238,095</u>
Funds Available for Operations	<u>\$519,694*</u>

*(Does not include \$73,787.72 collected from Penn Square Bank)

Thus, the association has approximately \$600,000 plus dues receivable for its 1983 operations.

The revenue and expense sections reflect normal increases in operations and income. *The Journal* lost a little more than in previous years, and the annual meeting sustained a much bigger loss than normal because there was no exhibit income. The association still showed a modest \$45,000 excess of income over expense. Even after writing down the extraordinary Penn Square adjustment, our net excess of revenues over expenses compares favorably with 1981.

The rest of the audit is a more detailed explanation of the association's various operations and are adequately explained in the accountants' notes.

BUDGET AND AUDIT COMMITTEE REPORT:

This committee's report is a review of the accountants' report to ascertain that it conforms and reflects the policies of the association. At the writing of this report the Budget and Audit Committee had not met; however, their report should be self-explanatory.

QUARTERLY REPORT:

The first quarter report in the revenue and expense section indicates a \$50,986 surplus in income over expense for the first 3-month period ending March 31. This is normal for this time of year since few of the major expenses (other than administrative), ie, AMA meetings, OSMA annual meetings, office supplies, etc, occur until the second and fourth quarters. In addition, a large portion

of the *Journal* income is paid in annual installments. The report does accurately reflect a positive income trend and a conservative expense trend.

1983 BUDGET:

The 1983 Budget projects a small excess of income over expense. Council budgets have been adjusted to accommodate increased activities and special projects such as the Medicare demonstration effort and the Cancer Research project, should the House decide to further investigate the feasibility of such a plan. Out-of-state travel has been increased to recognize the addition of the new AMA delegate and alternate delegate.

General membership expenses project normal inflationary increases, as well as personnel compensation and benefit adjustments normally adopted by the Board of Trustees at the annual meeting.

SUMMARY AND CONCLUSION:

The 1983 Budget proposal is a guide for association expenditures for the year. It is reflective of the programs submitted by the councils and the fixed operating expenses of the association. The proposal conservatively predicts annual income adequate to fund the projected program of the association.

Respectfully submitted,

Armond H. Start, MD
Secretary-Treasurer

OKLAHOMA STATE MEDICAL ASSOCIATION

GENERAL MEMBERSHIP EXPENSES

Salaries	\$290,000
Awards	4,000
Data processing	3,000
Dues and subscriptions	4,500
Equipment rental	25,000
Insurance	30,000
Interest	18,000
Legal and professional	12,000
Membership directory	24,000
Office supplies	25,000
OSMA Newsletter	4,800
Payroll taxes	20,000
Pension costs	20,000
Postage and shipping	20,000
Repairs and maintenance	12,000
Services	2,500
Staff and officers' expense	15,000
Telephone and utilities	35,000
Other general expense	<u>4,000</u>
	\$568,800

News / PROCEEDINGS

OKLAHOMA STATE MEDICAL ASSOCIATION 1983-84 Proposed Budget

	1982 Projected	1982 Actual	Projected
<i>Income</i>			
Membership Dues	\$540,000	\$582,595	\$591,000
Interest & Commissions	90,000	73,555	75,000
Lease Income	30,000	34,060	34,000
Directory Sales & Advertising	7,500	6,984	25,000
Advertising & Subscriptions	80,000	90,717	90,000
Annual Meeting	10,000	6,923	10,000
Contracts	100,000	100,000	100,000
Miscellaneous	5,000	4,683	5,000
Total	\$862,500	\$899,517	\$930,000

<i>Expenses</i>			
General Membership	\$560,000	\$493,423	\$568,800
Council Expense	40,000	77,210	80,000
In State Travel	7,500	2,058	4,500
Out-of-State Travel	55,000	57,028	65,000
Journal	80,411	140,921	120,000
Annual Meeting	50,000	65,793	45,000
Depreciation	16,000	17,600	18,000
Total	\$808,911	\$854,033	\$901,300
Surplus (Deficit)	\$ 53,589	\$ 45,484	\$ 28,700

OKLAHOMA STATE MEDICAL ASSOCIATION BALANCE SHEET March 31, 1983

<i>Current Assets</i>	
Cash	\$ 137,819
Savings accounts and certificates of deposit	411,570
Accounts receivable	137,114
Prepaid expenses	8,386
Total Current Assets	694,889
<i>Property and Equipment</i>	
Land	7,808
Building	379,515
Pavement	2,451
Furniture, fixtures and equipment	137,291
Equipment under capital lease	25,650
	552,715
Less: Accumulated depreciation and amortization	101,322
	451,393
<i>Investment in Subsidiary</i>	3,587,102
<i>Other Assets</i>	
Deposits	1,983
Loan Acquisition costs—Net of amortization	5,050
Organization expense—Subsidiary	41,895
Accounts receivable—FDIC	137,614
	186,542
Total	\$4,919,926

LIABILITIES AND FUND BALANCES

<i>Current Liabilities</i>	
Current portion of long-term liabilities	\$ 5,611
Current obligation under capital lease	3,816
Accounts payable	154,518
Loans and scholarships payable	200
Accrued liabilities	9,619
Retirement expense	13,200
Deferred income	460,276
Total Current Liabilities	647,240
<i>Long-Term Liabilities</i>	
Notes payable	144,207
Less: Current portion included above	5,611
	138,596
<i>Long-Term Obligation Under Capital Lease</i>	
Notes payable	8,705
Less: Current portion included above	3,816
	4,889
<i>Fund Balances</i>	
Appropriated for public education	35,619
Appropriated for building maintenance	30,217
Unappropriated	4,063,365
	4,129,201
Total	\$4,919,926

OKLAHOMA STATE MEDICAL ASSOCIATION STATEMENT OF CHANGES IN FUND BALANCES FOR THE MONTHS ENDED MARCH 31, 1983

<i>Appropriated For Public Education</i>	
Beginning of period	\$ 35,619
Contribution from Central Oklahoma Council of Medical Staffs	—
End of period	35,619
<i>Appropriated For Building Maintenance</i>	
Beginning of period	30,217
Appropriation for period	—
End of period	30,217
<i>Unappropriated</i>	
Beginning of period	3,999,828
Excess of revenue over expenses	63,537
End of period	4,063,365
Total	\$4,129,201

OKLAHOMA STATE MEDICAL ASSOCIATION STATEMENT OF REVENUES AND EXPENSES FOR THE MONTHS ENDED MARCH 31, 1983

<i>From Operations</i>	
Revenue	\$ 172,990
Expenses	122,004
Excess of Revenue Over Expenses	
From Operations	\$ 50,986
<i>Journal</i>	
Revenue	27,322
Expenses	26,770
Excess of Expenses Over Revenue	
From Journal	(552)
<i>Annual Meeting</i>	
Revenue	11,383
Expenses	3,990
Excess of Revenue Over Expenses	
From Annual Meeting	7,393
<i>Other Revenue (Expenses)</i>	
Special assessment	11,695
Amortization of organization expense—Subsidiary	(5,985)
	5,710
Net Excess of Revenues Over Expenses	\$ 63,537

OKLAHOMA STATE MEDICAL ASSOCIATION
SCHEDULE OF REVENUES
FOR THE MONTHS ENDED
MARCH 31, 1983

<i>From Operations</i>	
Membership dues	\$ 144,680
Interest and commissions	5,576
Building lease income	7,860
Membership directory	625
Computer income	1,186
Miscellaneous	13,063
Total Revenue	<u>172,990</u>
<i>From Journal</i>	
Subscriptions allocated from dues	7,680
Advertising and sales	19,090
Total Revenue	<u>\$ 26,770</u>

OKLAHOMA STATE MEDICAL ASSOCIATION
SCHEDULE OF EXPENSES
FOR THE MONTHS ENDED
MARCH 31, 1983

<i>General Membership Expenses</i>	
Salaries	\$ 66,662
Awards	808
Councils	26,288
Data processing	431
Depreciation and amortization of leased equipment	4,147
Dues and subscriptions	198
Equipment rental	7,403
Insurance	5,499
In-state travel	438
Interest	1,714
Legal and professional	300
Office supplies	5,050
Of-of-state travel and AMA convention expense	5,001
Payroll taxes	5,067
Pension costs	623
Postage and shipping	8,756
Repairs and maintenance	921
Services	1,191
Staff and officers' expense	1,844
Telephone and utilities	3,504
Other general expense	(2,894)
Total Before Allocation of Overhead	<u>142,911</u>
Expense reimbursement from subsidiary	<u>(20,907)</u>
Total General Membership Expenses	<u>122,004</u>
<i>Council Expenses</i>	
Governmental activities	8,524
Professional and public relations	12,926
Planning and development	3,640
Medical education	(50)
Medical services	416
Member services	832
Total Council Expenses	<u>\$ 26,288</u>

management letter dated February 23, 1983. It is our opinion that the report accurately reflects the income, expenses and financial condition of the Association.

Thomas N. Lynn, MD, Chairman
Larry L. Long, MD
Kenneth Whittington, MD

OKLAHOMA STATE MEDICAL ASSOCIATION
ACCOUNTANTS' REPORT
DECEMBER 31, 1982 and 1981

House of Delegates
Oklahoma State Medical Association
Oklahoma City, Oklahoma

We have examined the balance sheets of Oklahoma State Medical Association as of December 31, 1982 and 1981 and the related statements of revenues and expenses, changes in fund balances and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of Physicians Liability Insurance Company, a wholly owned subsidiary, which statements reflect total assets and net loss constituting 69 percent and 12 percent in 1982 and 41 percent and 2 percent in 1981, respectively, of the totals. These statements were examined by other auditors whose report thereon has been furnished to us, and our opinion expressed herein, insofar as it relates to the amounts included for Physicians Liability Insurance Company, is based solely upon the report of the other auditors.

Oklahoma State Medical Association does not provide for depreciation on buildings as is required by generally accepted accounting principles.

In our opinion, based upon our examinations and the report of other auditors, except as noted in the preceding paragraph, the financial statements referred to above present fairly the financial position of Oklahoma State Medical Association as of December 31, 1982 and 1981, the results of its operations and the changes in its financial position for the years then ended in conformity with generally accepted accounting principles applied on a consistent basis.

Moak, Hunsaker, Rouse & Co.
Oklahoma City, Oklahoma
January 28, 1983

Report of The
COMMITTEE ON APPROPRIATIONS
AND AUDITING

SUBJECT: Annual Report
PRESENTED BY: Thomas N. Lynn, Jr, MD,
Chairman
REFERRED TO: Reference Committee I

The Committee has reviewed the Accountants' Report prepared by Moak, Hunsaker, Rouse, Thomas & Co. and the supplemental material contained therein, including the

OKLAHOMA STATE MEDICAL ASSOCIATION
BALANCE SHEETS
DECEMBER 31, 1982 and 1981

ASSETS	1982	1981
CURRENT ASSETS		
Cash	\$ 24,197	19,503
Savings accounts and certificates of deposit	94,241	1,128,800
Accounts receivable	633,133	1,244,579
Accrued interest receivable	—	10,048
Prepaid expenses	<u>6,218</u>	<u>6,822</u>
Total Current Assets	<u>757,789</u>	<u>2,409,752</u>

News / PROCEEDINGS

PROPERTY AND EQUIPMENT—Partially pledged to secure long-term debt — Note 6 —

Land	7,808	7,808
Building	379,515	379,515
Pavement	2,451	2,451
Furniture, fixtures and equipment	135,345	128,475
Equipment under capital lease— Note 4	25,650	25,650
	<u>550,769</u>	<u>543,899</u>
Less: Accumulated depreciation and amortization	97,285	82,114
	<u>453,484</u>	<u>461,785</u>

INVESTMENT IN SUBSIDIARY— Note 2

3,587,102	2,098,832
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OTHER ASSETS

Due From Federal Deposit Insurance Corporation — Net of allowance of \$211,401 — Note 3	211,402	—
Loan acquisition costs— Net of amortization	5,160	5,600
Organization expense—Subsidiary— Net of amortization	47,880	71,820
Deposits	1,983	1,983
	<u>266,425</u>	<u>79,403</u>
TOTAL	<u>\$5,064,800</u>	<u>5,049,772</u>

The accompanying accountants' report and notes are an integral part of this statement.

LIABILITIES AND FUND BALANCES

1982	1981
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CURRENT LIABILITIES

Current portion of long-term debt—Note 6	\$ 8,967	7,549
Current obligation under capital lease—Note 4	6,676	5,019
Accounts payable — Note 5	209,047	150,417
Loans and scholarships payable	200	300
Accrued liabilities — Payroll taxes	—	83
Retirement plan — Note 7	13,200	15,700
Deferred income — Note 8	617,935	1,826,494
Total Current Liabilities	<u>856,025</u>	<u>2,005,562</u>

LONG-TERM DEBT — Note 6

Notes payable—Secured by partial pledge of property and equipment	146,368	154,435
Less: Current portion included above	8,967	7,549
	<u>137,401</u>	<u>146,886</u>

LONG-TERM OBLIGATION UNDER CAPITAL LEASE—Note 4

Lease payable—Secured by pledge of equipment	12,387	16,971
Less: Current portion included above	6,676	5,019
	<u>5,711</u>	<u>11,952</u>

COMMITMENTS AND RELATED PARTY TRANSACTIONS— Notes 9 and 13

— —

FUND BALANCES

Appropriated for loans and scholarships	—	—
Appropriated for public education	35,619	35,619
Appropriated for building maintenance	30,217	30,217
Unappropriated	3,999,827	2,819,536
	<u>4,065,663</u>	<u>2,885,372</u>
TOTAL	<u>\$5,064,800</u>	<u>5,049,772</u>

OKLAHOMA STATE MEDICAL ASSOCIATION STATEMENTS OF REVENUES AND EXPENSES FOR THE YEARS ENDED DECEMBER 31, 1982 and 1981

	1982	1981
FROM OPERATIONS		
Revenue	\$ 701,877	644,010
Expenses	547,319	504,619
Excess of Revenue Over Expenses From Operations	<u>154,558</u>	<u>139,391</u>
JOURNAL		
Revenue	90,717	81,556
Expenses	140,921	118,795
Excess of Expenses Over Revenue From Journal	<u>(50,204)</u>	<u>(37,239)</u>

ANNUAL MEETING

Revenue	6,923	14,190
Expenses	65,793	63,648
Excess of Expenses Over Revenue From Annual Meeting	<u>(58,870)</u>	<u>(49,458)</u>
Excess of Expenses Over Revenue Before Other Items and Extraordinary Item	<u>45,484</u>	<u>52,694</u>

OTHER REVENUE (EXPENSES)

Special assessment	1,231,878	1,210,132
Income (Loss) from investment in subsidiary	138,270	(14,618)
Amortization of organization expense— Subsidiary	<u>(23,940)</u>	<u>(23,940)</u>
	<u>1,346,208</u>	<u>1,171,574</u>
Net Excess of Revenues Over Expense Before Extraordinary Item	1,391,692	1,224,268

EXTRAORDINARY ITEM — Note 3

Net Excess of Revenues Over Expenses	<u>(211,401)</u>	<u>—</u>
	<u>\$1,180,291</u>	<u>1,224,268</u>

The accompanying accountants' report and notes are an integral part of this statement.

OKLAHOMA STATE MEDICAL ASSOCIATION
STATEMENTS OF CHANGES IN FUND BALANCES
FOR THE YEARS ENDED
DECEMBER 31, 1982 AND 1981

	1982	1981
APPROPRIATED FOR LOANS AND SCHOLARSHIPS—Note 10	\$	
Beginning of period	—	70,565
Appropriated for period	—	—
Loan repayments	—	20,000
Transferred to unappropriated	—	(90,565)
End of period	—	—
APPROPRIATED FOR PUBLIC EDUCATION—Note 11		
Beginning of period	35,619	35,619
Appropriated for period	—	—
End of period	35,619	35,619
APPROPRIATED FOR BUILDING MAINTENANCE—Note 12		
Beginning of period	30,217	30,217
Appropriated for period	—	—
End of period	30,217	30,217
UNAPPROPRIATED		
Beginning of period	2,819,536	1,504,703
Excess of revenue over expenses	1,180,291	—
Transferred from appropriated for loans and scholarships	—	90,565
End of period	3,999,827	2,819,536
TOTAL	<u>\$4,065,663</u>	<u>2,885,372</u>

The accompanying accountants' report and notes are an integral part of this statement.

OKLAHOMA STATE MEDICAL ASSOCIATION

STATEMENTS OF CHANGES IN FINANCIAL POSITION
FOR THE YEARS ENDED DECEMBER 31, 1982 and 1981

WORKING CAPITAL PROVIDED	1982	1981
From operations —		
Excess of revenues over expenses before extraordinary item	\$ 1,391,692	1,224,268
Expenses (Income) not affecting working capital during the current period —		
Equity in loss (income) of subsidiary	(138,270)	14,618
Depreciation and amortization	41,980	39,696
Total From Operations	1,295,402	1,278,582
Transfer from appropriated for loans and scholarships	—	20,000
Total Working Capital Provided	<u>1,295,402</u>	<u>1,298,582</u>
WORKING CAPITAL USED		
Purchase of property and equipment	9,299	21,310
Investment in subsidiary	1,350,000	1,000,000
Reclassification of amounts due from Penn Square Bank	422,803	—
Payments on long-term debt	9,485	7,655
Payments on long-term obligation under capital lease	6,241	5,413
Total Working Capital Used	<u>1,797,828</u>	<u>1,034,378</u>

Increase (Decrease) in Working Capital	\$ (502,426)	264,204
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CHANGES IN WORKING CAPITAL

Current assets —		
Cash	\$ 4,694	7,881
Savings accounts and certificates of deposit	(1,034,559)	218,541
Accounts receivable	(611,446)	226,609
Accrued interest receivable	(10,048)	2,896
Prepaid expenses	(604)	(124)
Increase (Decrease) in Current Assets	<u>(1,651,963)</u>	<u>455,803</u>
Current liabilities —		
Current portion of long-term debt	1,418	290
Current obligation under capital lease	1,657	609
Accounts payable	58,630	22,856
Loans and scholarships payable	(100)	(100)
Accrued liabilities	(2,583)	3,915
Deferred income	(1,208,559)	164,029
Increase (Decrease) in Current Liabilities	<u>(1,149,537)</u>	<u>191,599</u>
Increase (Decrease) in Working Capital	<u>\$ (502,426)</u>	<u>264,204</u>

The accompanying accountants' report and notes are an integral part of this statement.

OKLAHOMA STATE MEDICAL ASSOCIATION
NOTES TO FINANCIAL STATEMENTS
FOR THE YEARS ENDED
DECEMBER 31, 1982 and 1981

(1) Significant Accounting Policies —

The following is a summary of certain significant accounting policies followed in the preparation of these financial statements. Except for the omission of depreciation on the building, these policies conform to generally accepted accounting principles:

Property and equipment —

Property and equipment, including the capitalized lease, is recorded at cost. Depreciation of the property, except the building, is computed using the straight-line method. Depreciation is not provided on the building. Depreciation is computed over the following estimated useful lives:

	Years
Furniture, fixtures and equipment	3-10

Capital lease —

The capital lease is accounted for under the Statement of Financial Accounting Standards No. 13, Accounting For Leases. Under this method of accounting for capital leases, the asset is amortized on a straight-line basis over the useful life of the asset (ten years) and the obligation, including interest thereon, is liquidated over the life of the lease.

Deferred income —

All income is prorated over the period to which it applies.

Investment in subsidiary —

Investment in subsidiary is accounted for by the equity method. Under this method the Association's equity in the net earnings or losses of the subsidiary is included currently on the Association's statement of revenue and expenses. Any dividends received from the subsidiary will be reflected as a reduction of the investment. The carrying value of the investment approximates the underlying equity of the subsidiary.

News / PROCEEDINGS

Loan acquisition costs —

Loan acquisition costs are amortized on a straight-line basis over the life of the loan.

Organization expense — Subsidiary —

Organization expense is amortized on a straight-line basis over a five-year period.

Organization —

The Association was organized as a nonprofit organization and, as such, is exempt from income taxes under Section 501 (c) (6) of the Internal Revenue Code.

(2) Investment in Subsidiary —

On May 3, 1979 the House of Delegates of the Association passed a resolution empowering the members of the Board of Trustees of the Association to organize and form an insurance company wholly owned by the Association for the purpose of writing professional liability and related lines of insurance on Oklahoma physicians. On October 17, 1979 Physicians Liability Insurance Company was formed and capitalized by the Association in the sum of \$150,000 in capital stock and an initial \$1,000,000 of paid-in capital. Subsequent to 1979, additional contributions have been made to paid-in capital by the Association from funds provided by special assessments to its members.

(3) Due From Federal Deposit Insurance Commission —

The Association had cash on deposit and certificates of deposit totaling \$679,187 in Penn Square Bank of Oklahoma City, Oklahoma in July, 1982 when the Bank was closed by the Federal Deposit Insurance Corporation (FDIC). Of this amount, \$243,071 was determined by the FDIC to be covered by its insurance and has been recovered by the Association. The remainder, however, is being reflected as a receivable from the FDIC and will be repaid only as the ultimate liquidation of the Bank's assets permit and only in the amounts available to other unsecured creditors on a pro rata basis. For financial purposes, this receivable has been valued at approximately 50 percent of its face value.

(4) Long-Term Obligation Under Capital Lease —

The following is a schedule by years of future minimum payments under the capital lease together with the present value of net minimum lease payments as of December 31, 1982:

Fiscal Year ending December 31 —	
1983	\$ 6,984
1984	6,984
1985	179
Total Minimum Lease Payments	14,147
Less: Amount representing interest	1,760
Present Value of Net Minimum Lease Payments	12,387
Less: Current portion of obligation under capital lease	6,676
Long-Term Obligation Under Capital Lease	\$ 5,711

Amortization of leased property under the capital lease was \$2,526 for the year ended December 31, 1982. Interest expense on the outstanding obligation under the capital lease was \$1,818 for the year ended December 31, 1982.

(5) Accounts Payable —

The following is a summary of the accounts payable:

	1982	1981
Trade	\$ 36,845	16,873
Dues	46,725	14,741
Leebron Memorial Fund	6,440	5,755
Medical education endowment	105,955	111,555
Physicians Liability Insurance Company—Subsidiary	82	1,493
Other	13,000	—
Total	\$ 209,047	150,417

(6) Long-Term Debt —

The following is a summary of long-term debt:

	1982		1981	
	Current Portion	Long-Term Portion	Current Portion	Long-Term Portion
Installment note payable to a company—Secured by equipment—Payable in 60 monthly payments of \$489 including interest at 11 percent — Commencing January, 1979	\$ 5,536	—	4,961	5,536
Installment note payable to a company — Secured by real estate — Payable in 180 monthly payments of \$1,448 and one payment of \$69,548 at the end of note including interest at 10 percent — Commencing November, 1979	3,431	137,401	2,588	141,350
	<u>\$ 8,967</u>	<u>137,401</u>	<u>7,549</u>	<u>146,886</u>

Amounts due on long-term debt in future years as of December 31, 1982 are as follows:

1984	\$ 3,686
1985	4,188
1986	4,627
1987	5,111
1988	5,647
1989-1993	38,441
1994 (Term)	75,701
	<u>\$ 137,401</u>

(7) Retirement Plan —

The Association has a defined benefit pension plan which covers employees who are twenty-four and one-half years of age or older and have at least six months of service. The plan has a fiscal year of June 1 to May 31. The total pension expense for 1982 and 1981 is \$21,524 and \$32,457, respectively. The amount of accrued pension expense for the year is funded by the Association in annual contributions to the pension plan. The actuarial present value of the accumulated benefits to participants of the plan and the net assets available for those benefits as of the beginning of the plan year 1981-1982 is as follows:

	1983	1982
Actuarial present value of the accumulated plan benefits* —		
Vested	\$ —	38,741
Nonvested	—	4,645
Total	<u>\$ —</u>	<u>43,386</u>
Net assets available for benefits	<u>\$ 81,020</u>	<u>67,053</u>

*The actuarial present values for 1983 have not as yet been calculated by the Association's actuary.

In determining the actuarial present value of the accumulated plan benefits, an assumed weighted average rate of 6 percent was used.

(8) Deferred Income —

The following is a summary of deferred income:

	1982	1981
Dues		
Annual meeting	\$ 617,935	604,060
Special assessment — 1982	—	1,038
	<u>—</u>	<u>1,221,396</u>
	<u>\$ 617,935</u>	<u>1,826,494</u>

On May 3, 1979 the House of Delegates passed a resolution establishing a special assessment. The proceeds of such assessments are to be used exclusively for payments of the costs of forming and funding Physicians Liability Insurance Company, a wholly owned subsidiary of the Association. The assessments were not to exceed \$2,000 per insured physician who was a member of the Association. The assessments were due on an installment basis over a three-year period beginning January 1, 1980 and ending on January 1, 1982.

The deferred special assessment income as of December 31, 1981 was comprised of receipts of \$614,726, plus unpaid special assessments billed in advance of \$606,670.

(9) Commitments —

Long-term leases —

The following is a summary, by year, of lease agreements entered into by the Association at December 31, 1982:

	1983	1984	1985	1986
Automobiles	\$ 17,535	13,271	6,464	2,373

(10) Appropriated for Loans and Scholarships —

Prior to 1980 the Association voted to appropriate a portion of its dues income for the purpose of making loans to certain medical students qualifying under terms specified by the Association. By a vote of the House of Delegates, this program was discontinued in 1981 and the appropriated fund balance was transferred to the unappropriated fund balance.

(11) Appropriated For Public Education —

During the fiscal year ended May 31, 1976, the Board of Trustees authorized the amounts collected through special assessments to be transferred to the portion of the fund balance appropriated for public education. The appropriation is to be used to inform the general public of governmental, legislative and bureaucratic regulations over the medical profession and the public.

(12) Appropriated for Building Maintenance —

For years prior to 1980, the Board of Trustees had adopted the procedure of appropriating 25 percent of the net operating revenue for each period toward building maintenance. Effective for the year ended December 31, 1980, the Board of Trustees rescinded the 25 percent appropriation.

(13) Related Party Transactions —

For the years ended December 31, 1982 and 1981, the Association had an agreement with Physicians Liability Insurance Company, a wholly owned subsidiary, to provide loss prevention services for the insurance company. The Association was reimbursed \$100,000 and \$77,500, respectively, for their expenses on the project.

(14) Professional Liability Stabilization —

The Professional Liability Stabilization Program was established during the year ended May 31, 1976 by assessing the doctors a 15 percent surcharge on their basic professional liability policies. The Insurance Company of North America provided the basic \$100,000/\$300,000 policy. This money is under the control

of two trustees, one appointed by the Association and one appointed by the insurer. As of December 31, 1982 the balance on deposit was \$399,905, which is not included in the financial statements. The funds will be used if the insurer's reserves are exhausted through payment of claims.

(15) Professional Liability Excess Coverage —

During the fiscal year ended March 31, 1977, an insurance plan was formed with Hartford and Lloyd's of London to provide excess professional liability coverage. The excess liability policy was to cover losses in excess of \$100,000 and less than \$1,000,000 that exceed \$3.25 million per year. In accordance with the plan, a specified portion of the insurance premiums were deposited in a bank in the name of Oklahoma State Medical Association. The balance of the account on December 31, 1982 was \$1,208,669, which is not included in the financial statements. The funds will be used if the insurers' reserves are exhausted through payment of claims.

SUPPLEMENTAL MATERIAL

House of Delegates
Oklahoma State Medical Association
Oklahoma City, Oklahoma

Our examinations of the financial statements included in the preceding section of this report were directed to an expression of our opinion on those statements taken as a whole. The supplemental material presented in the following section of this report has been subjected to certain audit procedures applied in connection with our examinations of the financial statements. This information, while not considered necessary for the fair presentation of the financial position, results of operations and changes in financial position of the Association, is in our opinion fairly stated in all material respects when considered in relation to the financial statements taken as a whole.

Moak, Hunsaker, Rouse & Co.
Oklahoma City, Oklahoma
January 28, 1983

OKLAHOMA STATE MEDICAL ASSOCIATION SCHEDULE OF REVENUES FOR THE YEARS ENDED DECEMBER 31, 1982 and 1981

	1982	1981
FROM OPERATIONS		
Membership dues	\$ 582,595	460,558
Interest and commissions	73,555	117,503
Building lease income	34,060	30,540
Membership directory	6,984	25,912
Underwriting and risk management surcharge income	161	6,548
Computer income	4,522	2,949
Total Revenue		
From Operations	\$ 701,877	644,010
FROM JOURNAL		
Subscriptions allocated from dues	\$ 31,431	31,340
Advertising and sales	59,286	50,216
Total Revenue		
From Journal	\$ 90,717	81,556

OKLAHOMA STATE MEDICAL ASSOCIATION
SCHEDULES OF EXPENSES
FOR THE YEARS ENDED
DECEMBER 31, 1982 AND 1981

GENERAL MEMBERSHIP EXPENSES	1982	1981
Salaries	\$ 263,360	228,800
Awards	4,876	1,300
Councils	77,210	28,133
Data processing	2,830	3,059
Depreciation and amortization of leased equipment	17,600	15,317
Dues and subscriptions	4,305	4,083
Equipment rental	24,775	12,832
Insurance	29,493	31,934
In-state travel	2,058	4,484
Interest	17,432	20,412
Legal and professional	11,323	14,700
Loss prevention project	38,161	28,924
Membership directory	—	16,945
Office supplies	23,632	16,017
OSMA Newsletter	—	1,102
Out-of-state travel and AMA convention expense	57,028	50,717
Payroll taxes	19,421	17,375
Pension costs	21,524	32,457
Postage and shipping	23,131	17,711
Repairs and maintenance	10,295	18,598
Services	2,032	3,050
Staff and officers' expense	13,328	13,034
Telephone and utilities	32,444	28,520
Other general expense	1,866	11,593
Total Before Allocation of Overhead	698,124	621,097
Expense reimbursement from subsidiary	(100,000)	(77,500)
Overhead allocated to <i>Journal</i>	(23,963)	(14,191)
Overhead allocated to annual meeting	(26,842)	(24,787)
Total General Membership Expenses	\$ 547,319	504,619
COUNCIL EXPENSES		
Governmental activities	\$ 32,337	9,525
Medical education	230	(297)
Medical services	(1,077)	849
Member services	(1,051)	4,710
Planning and development	7,187	5,200
Professional and public relations	39,553	7,843
Public and mental health	31	303
Total Council Expenses	\$ 77,210	28,133
JOURNAL EXPENSES	1982	1981
Salaries	\$ 36,000	36,000
Advertising	17,452	11,674
Artwork	3,132	2,150
Printing	51,990	49,672
Proofreading	814	785
Supplies and other	7,570	4,323
Total Before Allocation of Overhead	116,958	104,604
Overhead allocated from general membership expenses	23,963	14,191
Total <i>Journal</i> Expenses	\$ 140,921	118,795

Report of the
COUNCIL ON LONG RANGE
PLANNING AND DEVELOPMENT

SUBJECT: Annual Report

PRESENTED BY: James B. Pitts, Jr, MD,
Chairman

REFERRED TO: Reference Committee I

INTRODUCTION:

This council was established for two primary purposes; one, to bring together the chairmen of the other association councils two times each year to discuss their programs in hopes of coordinating all association activities and to assess their progress in light of current events. Second, the council attempts to anticipate the future of medical practice and to initiate long range plans to cope with indicated changes.

ACTIVITIES:

The council has met twice this year; in the early fall and early spring. Both were two-day sessions starting on Saturday morning and ending on Sunday afternoon. Each meeting was held at a state lodge. Both meetings were extremely well attended and likewise productive. Each council chairman was given an opportunity to fully discuss the activities of his council to detail problems, successes and request assistance. AMA Delegates and Alternates were present and participated fully. Issues that needed national attention were referred to the AMA Delegation; state and local issues were similarly handled. Resolutions were drafted for referral to the Board of Trustees. The association's financial affairs were discussed, as were council budgets.

The long range planning responsibilities of the council have been more difficult to deal with. The multiple state and federal initiatives seem to be spontaneous and extremely difficult to predict. Private sector efforts, while known, have resulted in a variety of payment methods for patients that were not even known two years ago. Who could have predicted two years ago that Tulsa would have two HMOs and three PPOs in 1983. The AMA Health Policy Agenda for the American People, when completed, might help us in our future planning.

SUMMARY AND CONCLUSIONS:

The council serves a useful purpose; its meetings are the only time during the year that council chairmen and officers of the association, including AMA Delegates and Alternates, meet in extended session to discuss association business. The work products of the council meetings are included in various council and committee reports, and in resolutions presented to the House of Delegates.

The budgets of the various councils have been reviewed, as have their recommended programs to the House of Delegates. The council considers these to be an excellent program of activities for the association and recommends approval by the delegates.

1983 BUDGET REQUEST: \$4,000.00

Respectfully submitted,
James B. Pitts, Jr, MD, Chairman
Frank L. Adelman, MD
Elvin M. Amen, MD
John A. Blaschke, MD
Kent A. Braden, MD
Ed L. Calhoon, MD
M. Joe Crosthwait, MD
J. B. Eskridge III, MD
Michael J. Haugh, MD
William L. Hughes, MD
George H. Kamp, MD
Perry A. Lambird, MD
William M. Leebron, MD
Larry L. Long, MD
John A. McIntyre, MD
Floyd F. Miller, MD
Robert G. Perryman, MD
Victor L. Robards, MD
William R. Smith, MD
Armond H. Start, MD
Orange M. Welborn, MD

Report of the CONSTITUTION AND BYLAWS COMMITTEE

SUBJECT: Annual Report
PRESENTED BY: Stanley R. McCampbell,
MD, Chairman
REFERRED TO: Reference Committee I

INTRODUCTION:

The Bylaws of the Oklahoma State Medical Association specify that the duties of the Constitution and Bylaws Committee shall be to consider amendments proposed by mem-

bers of the Association or by component societies to the Association's Constitution and Bylaws; and, if it so chooses, to initiate such amendments.

REPORT:

Only one proposed amendment to the Bylaws was submitted during 1982-83. However, it was not necessary for the committee to meet to consider this proposal.

The amendment is contained in a resolution authored by Dr J. Wildey Morrison, and proposes specific language to make membership in the American Medical Association voluntary. The language contained in the resolution has been approved by this committee on at least four different occasions in past years and is still appropriate.

Respectfully submitted,
Stanley R. McCampbell, MD, Chairman
Jerold D. Kethley, MD
C. S. Lewis, Jr, MD
Arnold G. Nelson, MD
James B. Eskridge III, MD
David Browning, Jr, MD
Floyd F. Miller, MD
Raymond L. Cornelison, Jr, MD
J. B. Wallace, MD

Special Report of THE PHYSICIANS LIABILITY INSURANCE COMPANY

SUBJECT: Annual Report for 1982
PRESENTED BY: C. Alton Brown, MD, President
REFERRED TO: Reference Committee I

INTRODUCTION:

The Physicians Liability Insurance Company completed three years of operations on December 31, 1982.

PLICO's strong performance in the multi-line business of professional liability, medical, and dental insurance continues — and the level of acceptance the company has received from members of the Oklahoma State Medical Association is both heartening and appreciated by your company's Board of Directors.

This unique two-way flow of trust between the insurer and its insureds is built upon a solid portfolio of insurance products needed by the exclusive market PLICO serves. There is also a long-standing tradition of OSMA members to band together where malpractice

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protection is concerned. This loyalty has carried over to the PLICO Health programs offered for the first time on February 1, 1982.

In this 1982 Annual Report, PLICO's Board of Directors will present an overview of company operations, achievements and financial highlights for the past year.

INSURANCE COVERAGES:

PLICO's professional liability program leads the nation in any quality and cost comparison. Your company's premium rates are the lowest countrywide — certainly much lower than any other company whose policy features the desirable "Occurrence" type of coverage, and much lower in the long run than the inferior "Claims Made" policy sold by some carriers. This favorable comparison holds true against all commercial companies and all other doctor-owned insurers like PLICO. The broadest coverage available is another valued feature of PLICO's policy. High limits of protection up to \$5,000,000 a claim are routinely made available to the six risk classes of physician specialists and even higher limits may be acquired on an individual basis.

PLICO Health's array of major medical, Medicare supplement, and dental care options not only offer broader coverages and more generous payment allowances than the competition, but do so at premium rates 40 to 50% less — a collective savings of at least \$1.6 million under the market.

Your PLICO Board recognizes that its responsibility is to do your bidding. Accordingly, a referendum of insured physicians was conducted to determine whether or not outpatient psychiatric benefits should be included in the PLICO Health policy. You voted "No" by a vote of 71% to 29%! The question is still under study, and periodically the OSMA membership will be polled again on this and other coverage issues.

PLICO Health is managed by a special committee of the Board. Members are Eugene Feild, MD, Chairman; David Bickham, C. Alton Brown, MD; Wayne Coventon (Clinic Manager); Bill R. Goetzinger, MD; Ray V. McIntyre, MD; Floyd F. Miller, MD; and Armond H. Start, MD.

LOW OVERHEAD:

A recent study of the overhead costs of

commercial carriers and medical society-owned or sponsored companies reveals that PLICO's operational costs are the lowest in the nation. This low management fee converts into proportionately more of the premium dollar being left for claims and defense costs. PLICO's management costs are only 12% of premium income, but if this expense factor were to rise to the level of other carriers, 23.6% of each premium dollar would be drained off to overhead.

MARKET SHARE:

PLICO's professional liability insurance plan essentially saturates the Oklahoma market of practicing physicians.

The PLICO Health product line reached an enrollment of 1,972 physicians by year-end — about 55% of the total available market. In addition, 4,000 physicians' employees entrust their health to PLICO. When spouses and dependent children are considered, 14,938 persons are insured.

The OSMA members' tendency to pull their insurance purchasing power together into a professional liability pool is also being observed in the equally essential health insurance program. Although the health coverage plan is already actuarially sound, it is expected that much greater enrollment gains will be made in 1983, as PLICO's price advantage and more generous benefits continue to outperform the competition.

FINANCIAL CONDITION:

Net premium income earned for the 1982 professional liability program totalled \$9,475,204. Assets at year-end were \$18,278,789, up \$4,345,664 from 1981.

PLICO Health produced about \$4,000,000 of the total premium income over an eleven-month period ending December 31st.

The complete Balance Sheet and Statement of Operations of PLICO appears on the back panel of this Annual Report.

CLAIMS PICTURE:

In 1982, 8 professional liability claims were paid in the total amount of \$329,252, and for the entire three-year period of PLICO operations, there were 70 claims paid in the sum of \$4,535,460 — \$2,260,621 of which was paid by PLICO's reinsurer or from other sources. Actual 1980-82 premium reserves for unpaid claims which were pending at year-end totalled \$7,880,391 — but this figure is

cautiously developed up to \$11,914,441 on the accompanying Balance Sheet in order to accommodate unreported claims for the three-year period.

The company's Claims Committee — which works with management personnel in trial decisions, settlement negotiations, and claims valuations — is comprised of John A. McIntyre, MD, Chairman; Ed L. Calhoon, MD; James B. Eskridge III, MD; Eugene G. Feild, MD; Billy R. Goetzinger, MD; and Edward K. Norfleet, MD.

RETURN ON INVESTMENT:

PLICO's Investment Committee — comprised of C. S. Lewis, Jr, MD; David Bickham; and Edward Soule, LLB — reports investment income of \$2,083,792, up \$612,697 from 1981. These earnings represent a Return on Investment of 12.9% for the year. Investments are on an approximate 50-50 balance between certificates of deposit in \$100,000 increments and A-rated corporate bonds.

Investment income is utilized in company operations and more than offsets the management fee, leaving 100 cents on the dollar for claims and defense costs.

Twenty percent of PLICO's deposits in the Penn Square Bank have been received from the FDIC in addition to the insured amount initially returned, leaving a balance of \$488,746.85. Recovery of this amount is hoped for in the not too distant future.

Certificate of deposit investments are now limited to \$100,000 per bank until September, as the condition of the banking industry is further evaluated.

LOSS PREVENTION:

The company's Loss Prevention Committee, chaired by Ray V. McIntyre, MD, has been particularly active and effective. In 1982, six regional Loss Control Seminars attracted a physician registration of 1,232, all of whom received a 5% discount on their 1983 professional liability premiums for attending. Four more seminars of this type are scheduled for July, 1983. The committee has also analyzed the loss experience of several specialty groups, and is presently circulating a patient selection protocol and special surgical consent form to those physicians performing the gastric stapling procedure. A study of neonatal costs and risks is also underway by an ad hoc committee appointed by the Board of Direc-

tors, and the In Vitro Fertilization process has been carefully evaluated.

Other committee members are: David Bickham, Ed L. Calhoon, MD, and Floyd F. Miller, MD.

1983 PLANS:

Your Board of Directors and its management company will continue their efforts in 1983 to protect the professional liability program's great base of strength — its *total* support from the OSMA membership — against any penetration or fragmentation by the "Claims Made" carrier that ineffectively entered the Oklahoma marketplace last year.

Increased enrollment in the PLICO Health program will also be a major goal, since the same full participation advantage enjoyed in the professional liability field is equally important to the health insurance program in reaching its ultimate potential of savings and service to the medical community.

PLICO Health's "Wellness Bonus" will be re-evaluated as a utilization control device by surveying the 1982 recipients to assess their motives or circumstances that facilitated a claims-free year.

Your company's goal of improved electronic data processing capability should be fully realized in 1983, enabling PLICO's management company to quickly perform a variety of loss analysis studies, to shorten the turnaround time on health claims processing, and to expedite billing and policy issuance.

All in all, PLICO plans with confidence to make the best insurance company even better in the months and years ahead.

Respectfully submitted,
C. Alton Brown, MD, President
David Bickham, Vice-President
Armond H. Start, MD, Secretary-Treasurer

PLICO STATEMENT OF OPERATIONS December 31, 1982

REVENUES	
Net Premiums Earned	\$ 9,475,204
Investment Income	2,083,792
	<hr/> \$11,558,996
EXPENSES	
Losses	\$ 9,009,136
Loss Adjustment Expenses	296,737
Operating Expenses	1,767,386
Loss on Investment	305,467
	<hr/> \$11,378,726

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INCOME BEFORE TAXES AND EXTRAORDINARY CREDIT	\$ 180,270
TAXES ON INCOME	67,000
NET INCOME BEFORE EXTRAORDINARY CREDIT	\$ 113,270
EXTRAORDINARY CREDIT	25,000
NET INCOME	\$ 138,270
DEFICIT, BEGINNING OF YEAR	(51,168)
RETAINED EARNINGS	\$ 87,102

PLICO BALANCE SHEET December 31, 1982

ASSETS	
Cash	\$ 948,567
Investments	16,942,142
Premiums Receivable	82,126
Interest Receivable	280,377
Other	25,577
TOTAL ASSETS	\$18,278,789
LIABILITIES AND STOCKHOLDERS' LIABILITIES	
LIABILITIES	
Unearned Premium	\$ 1,463,209
Losses and Loss Adjustment Expenses	11,914,441
Reinsurance Premium Payable	797,603
Commissions Payable	103,885
Management Fee Payable	370,549
Deferred Income Taxes	42,000
TOTAL LIABILITIES	\$14,691,687
STOCKHOLDERS' EQUITY	
Common Stock	\$ 150,000
Additional Paid-In Capital	3,350,000
Retained Earnings	87,102
TOTAL STOCKHOLDER'S EQUITY	\$ 3,587,102
TOTAL LIABILITIES AND STOCKHOLDERS' EQUITY	\$18,278,789

PLICO SHAREHOLDERS' REPORT

May 4, 1983

I am pleased to report that PLICO has had another successful year, both as a Professional Liability insurer and as a Hospitalization insurer. Your Company received premiums of \$5,673,462 for professional liability and \$3,801,740 from its hospitalization division, for a total income of \$9,475,203 in 1982. Our surplus and capital totalled \$3,323,635 and at the end of the year, the total assets of PLICO were \$18,278,786.

In the Professional Liability Division, PLICO's incurred losses totalled \$5,636,942. This continuing good loss experience made it possible to keep the 1982 gross cost to most physicians at or below the level which we had experienced in the first three years of the Company's operation. However, the year 1982 marked the first year that no assessment was secured from the members of the Association

so all of the monies received constituted premium income to the Company. This was important as it marked the end of the period of capitalization of PLICO, but also it made it possible to produce an increase in premium income without producing an increase in cost to you. So, the first four years of operation have been completed with no increase in professional liability insurance cost to Oklahoma physicians and at a lower per annum cost to Oklahoma physicians than we experienced under the last year of commercial insurance with the Hartford Insurance Company. This has been accomplished while capitalizing our Company with almost \$4,000,000 of policyholders surplus.

I am also pleased to advise you that subsequent to the closing of the books on the 1982 fiscal year of PLICO, we received a 20% payment on the Penn Square Bank debt and have been advised to expect a large part of the balance when the legal disputes with the downstream banks are resolved.

Because of the low overhead of our operation and the fact that PLICO's income from investment has been exceptionally high, the Company has performed well and on a sound and conservative fiscal basis so that low cost and adequate reserves have happily been the earmarks of your captive's operation to date.

The loss experience as we predicted is still accelerating and the number of outstanding claims still increasing, but the rate is slowing and beginning to stabilize. This is to be expected. The number of physicians in our Association is not growing rapidly and our book of professional liability business is reaching a state of stable maturity. To contain our reinsurance costs, we have assumed slightly larger amounts of liability; however, your Company is still fully reinsured with the General Reinsurance Company, the largest, oldest and strongest reinsurer in the United States.

In the area of Loss Control, PLICO has been active in its efforts to wrestle with the problems of new procedures. As a physician-owned insurance company operated by physicians, we recognize that these new procedures are important to our patients and our profession, and our position is a positive one as regards them. We want to help physicians protect themselves against the risk inherent in applying new and useful medical technology. We do not wish to exclude or cancel those members of our profession who are intent on

advancing our science. By the same token, we are determined to protect the assets of PLICO that constitute both the investment and the security of all the members of the Association in every way possible. So, unlike commercial insurers who are inclined to cancel or restrict coverage for physicians doing new or experimental procedures, we have asked that physicians embarking on these kinds of projects observe the highest standards of care possible and without restricting or limiting their coverage in any way, we have requested that they use special consent forms and protocols so that all of us will not be unduly penalized if a spate of lawsuits is generated by their activities.

We are pleased that this positive approach gives every indication of proving successful and we think it is one of the outstanding advantages that we all enjoy by owning our own insurance company.

In addition, this year three new members have been named to your Board by order of the Board of Trustees of your Medical Association. Because of the insurance laws, they act as observers but provide us with a reserve of experienced people to replace those of us who will be leaving the Board in the future.

I am sad to report that Armond Start who has served PLICO since its beginning and also served the Medical Association as its Secretary and Treasurer, is leaving for Texas and has resigned from the Board of our Association. He will take the job of Medical Head of the Department of Corrections in Texas.

As regards your Hospitalization Division, PLICO had an excellent year in 1982. We received \$3,801,740 of premium and paid \$2,825,776 of losses, showing a total operating surplus of \$975,964, most of which will be paid as part of the Wellness Bonus which is currently being issued by your insurer to those who did not use their health insurance during the first year of PLICO's operation. So, the Health Insurance Program in 1982 was about a breakeven despite the extremely low premiums which we charged. In 1983, as you all know, your Board elected to increase the premium even though loss experience was satisfactory. This decision was made based upon the fact that inflation in hospital costs continues and new procedures continue to become available. And, although they are frequently very beneficial, they are often exceedingly expensive. In the light of the first

quarter of 1983, we are thankful we made the decision to apply the increase as the Accident and Health program is consuming the surplus it generated in 1982. This however may be a temporary aberration and in any event, will be one which can be easily corrected upon anniversary. Your A & H program is not intended to make money. We own this Company and our hope is that we can tune it so well that it will show us a very small but consistent surplus while, in effect, providing insurance to us members at cost.

As regards Outpatient Psychiatric coverage, there are a number of types of voluntary medical treatment which your PLICO hospitalization insurance policy, in common with virtually every other hospitalization policy, does not cover. Among these elective procedures is outpatient psychiatric treatment, elective cosmetic surgery, elective weight loss programs, and in vitro fertilization, to name a few. There are three insurers that we know of in Oklahoma who offer out-patient psychiatric coverage. That coverage is extremely limited — in particular to \$1,000.00 a year and \$25.00 per visit with 80% co-insurance and subject, of course, to the policy deductible. We asked our actuaries to determine what an appropriate price would be for this coverage. They advised us we could not offer out-patient psychiatric coverage on an individual elective basis. They pointed out that if we did this, only those who used the coverage would purchase it and thereby select against the plan. Ultimately, their cost would simply be the cost of their care plus the management cost which would accomplish nothing from their standpoint or PLICO's.

The actuaries suggested that we determine a price that could be distributed across the entire group. This was done. Your Board decided it was not wise to make a decision on an unusual coverage like this without a democratic vote of all the participants in the plan. All insured physicians were polled. The vote came back 71% opposed to adding the additional premium and limited coverage. We feel strongly that this was the most democratic way to determine whether or not an unusual coverage should be added to our policy. We know that the pricing that was indicated for this coverage is correct inasmuch as we had the benefit of the consultation of outside actuaries as well as our own. If PLICO should offer a coverage which the majority of

the participants in the hospitalization plan do not want, then only those who wish the coverage will continue to buy PLICO's insurance policies because the premiums of other companies that do not offer this additional coverage will be lower. We want to keep your insurance policy and your insurance company financially sound and strong. Actually, it is our duty to respond to the wishes of the Trustees and of the House of Delegates, and to serve the members of the Association. By employing a democratic vote, we have tried our best to do this.

The response to the Wellness Bonus appears promising and we have reached that point in time where it is statistically possible to begin to test its efficacy and we have requested that C. L. Frates and Company, our manager, begin the statistical analysis of its impact.

As is the custom of your Board at the end of each year, we study the expenses incurred by the Company and the services provided us by our management company. It is easy for us to evaluate the services. The only way we can determine if the costs themselves are in line is to compare them to those of other captive insurers and the commercial insurance market. We have done this each year since the Company started business and the results have been consistently gratifying and explain one of the reasons for our relatively low premium cost.

Our management cost per physician is half that of the average captive insurance company and we have the lowest incremental management cost of any of the captive insurers who are members of the Physicians Captive Insurance Company Association. All of the captive insurers, even those with the highest overhead and heaviest expenses, operate more economically than the average commercial insurance company. PLICO's cost is about one-third that of the average commercial insurer. Bests Insurance Guide identifies the casualty overhead of the Hartford Insurance Company as 36% of its premium income. PLICO's management cost is only 12% of our premium income and only about 7% of our total income. It is less by \$50,016 than the total income we enjoy from our investments so that each year you received a dollar and 16¢ worth of insurance for each dollar of premium you pay.

I am pleased that our management costs are low, but more important than that, I am pleased that we are getting a superior service for that price and that we have excellent claims control, exceedingly good records, prompt reporting, billing, policy issuance and consistently good performance in the delivery of the regular services that PLICO performs for us all. We have the advantage of having a service facility that home offices in our own state so we are able to get straight to the top people when we need help and get yes or no answers on a virtually instantaneous basis.

Furthermore, it is reassuring to know that our loss experience is current, accurate, and correct and that we can make the important management decisions relating to premiums and payment of claims with the assurance that we have all the facts at our command, and that the policies we established will be faithfully followed.

PLICO has been a great asset to Oklahoma physicians and we have shown our enthusiastic support for PLICO in the most important of all ways. In January of 1983 virtually every doctor in Oklahoma renewed his insurance policy with PLICO and passed up the inferior claims made policy offered by the St Paul. This was, of course, an intelligent decision both from a cost and coverage standpoint by we Oklahoma physicians who understood the shortcomings of the St Paul policy. But, it also was a fine example of the strength of our Association and the fundamental reason why we have become a hallmark group in the AMA. I wish to thank you on behalf of your Officers and your Board. Your support has made our job easier and PLICO's success possible.

Respectfully submitted,
C. Alton Brown, MD, President

Report of the FINANCIAL AID TO EDUCATION COMMITTEE

SUBJECT: Education and Research Foundation

PRESENTED BY: David Bickham, Executive Director

REFERRED TO: Reference Committee I

Last year the House of Delegates instructed the Board of Trustees to investigate and establish an education and research foundation for

the purpose of soliciting funds to assist financially needy medical students.

Since that action of the House, this Committee has not actively pursued loans to medical students. It is assumed that the functions of this committee will be transferred to the newly formed ERF Board (see Report C of the Board of Trustees).

Report of REFERENCE COMMITTEE II

PRESENTED BY: John R. Alexander, MD,
Chairman

Mr. Speaker and Members of the House of Delegates:

Reference Committee II gave careful consideration to the several items referred to it and submits the following report:

(1) BOARD OF TRUSTEES REPORT B — CANCER RESEARCH PROJECT

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *the Board of Trustees Report B be adopted.*

(2) REPORT OF THE COUNCIL ON PROFESSIONAL AND PUBLIC RELATIONS

RECOMMENDATION:

Mr Speaker, your Reference Committee commends the Council on its job of carrying out those duties which were approved by last year's House of Delegates and recommends that *the Report of the Council on Professional and Public Relations be adopted.*

(3) REPORT OF THE PRESIDENT

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to express its most sincere appreciation for Dr John A. McIntyre's exceptional leadership and direction throughout the past year, and we recommend that *the Report of the President be filed for information.*

(4) REPORT OF THE COUNCIL ON PUBLIC AND MENTAL HEALTH

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to commend the Council on a job well done, and recommends that *the Report of the Council on Public and Mental Health be adopted.*

(5) REPORT OF THE COUNCIL ON MEDICAL EDUCATION

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to express its appreciation to this Council for the manner in which it carried out its activities and recommends that *the Report of the Council on Medical Education be adopted.*

(6) COUNCIL ON MEDICAL EDUCATION REPORT A — HEALTH MANPOWER SURVEILLANCE COMMITTEE

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Report A of the Council on Medical Education be adopted.*

(7) REPORT OF THE COUNCIL ON MEMBER SERVICES

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to express its appreciation to the Council for the fine work it has done this year, and recommends that *the Report of the Council on Member Services be adopted.*

(8) REPORT OF THE OSMA AUXILIARY

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to commend Mrs Betty Edge for her outstanding dedication and leadership and recommends that *the Report of the Auxiliary be filed for information.*

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(9) REPORT OF THE OKLAHOMA FOUNDATION FOR PEER REVIEW

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *the Report of the Oklahoma Foundation for Peer Review be filed for information.*

(10) REPORT OF THE JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to extend its gratitude to Mrs Louise Martin for her many years of dedicated service to the OSMA *Journal* and recommends that *the Report of the Journal of the Oklahoma State Medical Association be adopted.*

(11) REPORT OF THE PERINATAL TASK FORCE

RECOMMENDATION:

Mr Speaker, your Reference Committee heard much testimony concerning this subject and is satisfied that the task force is proceeding in a nondiscriminatory manner in attempting to find a solution to this situation, and your Reference Committee recommends that *the Report of the Perinatal Task Force be filed for information.*

(12) RESOLUTION 1 — JCAH

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 1 be adopted.*

(13) RESOLUTION 2 — NUCLEAR WAR

RECOMMENDATION:

Mr Speaker, your Reference Committee heard extensive testimony, both pro and con, concerning the medical implications of nuclear

war, and your Reference Committee recommends that *the following substitute resolution be adopted in lieu of Resolution 2:*

Resolved, That the Oklahoma State Medical Association support in concept the education of physicians regarding the medical aspects of nuclear injury.

(14) RESOLUTION 6 — INDIGENT PATIENT CARE

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 6 be adopted with the following addition:*

; and, be it further

Resolved, That the content and intent of this resolution be made public through proper channels at the appropriate time.

(15) RESOLUTION 11 — MEDICAL EDUCATION IN NUTRITION

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 11 be adopted with the following amendments:*

Delete the last word on line 4 through and including all of line 8 and add to the end of line 4 "therefore, be it" and, further, delete the word "seriously" in line 10 and the words "or all" in line 11.

(16) RESOLUTION 12 — HORSEBACK RIDING SAFETY

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 12 be adopted with the following word change:*

The last word in line 20 "require" be deleted and the word "encourage" be inserted.

(17) RESOLUTION 14 — PERINATAL INTENSIVE CARE

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 14 be adopted.*

(18) RESOLUTION 18 — PEER AND FEE REVIEW

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 18 be adopted*.

Mr Speaker, this concludes the Report of Reference Committee II. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,
John R. Alexander, MD, Chairman
Raymond L. Cornelison, Jr, MD
Robert Dix, MD
Richard E. Jones, MD
William H. Oehlert, MD
Tim K. Smalley, MD
Eric L. Westerman, MD
Rick Ernest, Staff
Susan Meeks, Staff

OKLAHOMA STATE MEDICAL ASSOCIATION BOARD OF TRUSTEES Report: B

SUBJECT: Cancer Research Project
PRESENTED BY: John A. McIntyre, MD,
President
REFERRED TO: Reference Committee II

INTRODUCTION:

Many attempts have been made over the past decade to establish a statewide cancer program in Oklahoma. For various reasons none were successful. It now appears there is good reason to believe that the various cancer interests in the state could be organized into a cooperative unit for the establishment of such a system. Officers and representatives of the association have met with most of the various cancer groups (Oklahoma Teaching Hospitals, Oklahoma Health Sciences Center and the medical school, Oklahoma Medical Research Foundation, cancer researchers, the Oklahoma Cancer Society, practicing oncologists, and a representative of the President's Advisory Commission on Cancer). We have also met with the Director of the Department of Human Services and state legislators.

OBJECTIVES OF A STATEWIDE CANCER PROJECT:

There are many unanswered questions about the scientific and practical value of such an effort. The only consensus at this early state of investigation is that a central cancer registry would: 1) centralize accurate demographic data on the kinds of, and treatment of cancer in the state; b) provide a resource for the future dissemination of information on the preferred treatment protocol for various cancers. There are perhaps other valid objectives, but at present these are the only two clearly identified.

REQUIREMENTS FOR A CENTRAL CANCER REGISTRY:

There are a number of approved cancer registries in the state. All are hospital based and utilize formal reporting protocols developed by the American College of Surgeons or the American Cancer Society. The statewide registry would adopt an approved protocol, encourage participation of existing registries, assist in the development of new participants, and provide for the dissemination of information. It would be imperative that data which is entered into the system and recalled be held in strictest confidence, especially as to patient and physician.

In all the discussions thus far it has been repeatedly emphasized that control of the central registry must be in the hands of a non-vested interest and a nonbiased entity.

ROLE OF THE OSMA:

Because of potential or perceived conflicts, it appears that OSMA is the best candidate to control the central registry. It is felt that because the association is an independent statewide organization representing almost all of the doctors that it would be in the best position to encourage and receive the cooperation from physicians and hospitals necessary to make such a project successful.

There are a number of possibilities for establishing such a system without having the full financial burden born by the association. The association can contract with a state agency such as the State Health Department to provide the service; a similar arrangement could be made with the Department of Human Services. The Foundation for Peer Review may be able to handle the registry. There is potential funding from federal, state, and private sources.

SUMMARY:

It appears that a proper sponsor could garner the necessary support from physicians and hospitals to start a statewide cancer registry;

While no financial studies have been completed, there are indications that there are state and federal, and perhaps private monies available to finance such a project;

Even though all the objectives of such a project have not been clearly identified, the research and practical application of a tumor registry justifies further investigation of such a project;

OSMA would be committing itself to a major undertaking should it attempt to establish a statewide cancer project.

RECOMMENDATION:

If the House of Delegates feels that OSMA should be instrumental in promoting a statewide cancer program, it is recommended they authorize the Board of Trustees to send association representatives to New Mexico and Connecticut to study the known statewide registries and to prepare a detailed feasibility report on the cost, objectives and initiation of such a program.

Respectfully submitted,
John A. McIntyre, MD
President

**Report of the
COUNCIL ON PROFESSIONAL
AND PUBLIC RELATIONS**

SUBJECT: Annual Report
PRESENTED BY: M. Joe Crosthwait, MD,
Chairman
REFERRED TO: Reference Committee II

INTRODUCTION:

The Council on Professional and Public Relations is responsible for the internal and external communications program of the Oklahoma State Medical Association. The overall goals of the council are (1) to improve and maintain communication and understanding among Oklahoma physicians, their patients, and the

public and (2) to keep members informed about programs, policies, and activities undertaken by the association and by other organizations affecting the practice of medicine in Oklahoma.

REVIEW OF ACTIVITIES:

During the past year the public relations and professional relations programs have concentrated on four areas: assessment of public opinion toward the medical profession and key health care issues; development of a closer relationship between OSMA and medical students; improvement of communication between physicians and their patients; and sponsorship of public service activities. All activities were conducted in accordance with the general program approved by the House of Delegates in 1982.

Here are the accomplishments of the council in these four areas:

1. *Assessment of public opinion toward the medical profession and key health care issues.* In 1982 the council commissioned a public opinion survey to assess the attitudes of Oklahomans toward the medical profession and important issues in medicine. The survey was coordinated with a similar nationwide survey commissioned by the American Medical Association. Survey subjects included: selection and retention of physicians; adequacy of physician supply; public image of physicians; validity of professional liability claims; responsibility for rising health care costs; relationship between personal habits and health; and national priorities for spending.

Results of the survey were published in the January 1983 issue of the *OSMA Journal*, and details of the survey were made available to key members and officers of the association. Survey results also were disseminated to state agencies and other medical organizations that requested the information. These results point out areas where the public and physicians disagree (eg, adequacy of physician supply), areas where they agree (eg, need to limit awards in professional liability cases), and, most important, areas where physicians and the association can work together to improve the public image of physicians in Oklahoma.

Information gathered by the survey has been incorporated into the planning process for several council projects aimed at improving the physician-patient relationship and enhancing the image of the profession in Oklahoma. (These projects are discussed later in the report.) With results of the survey in hand, the

association now has a yardstick to use in measuring changes in public opinion and in gauging the success of its programs in influencing public perception of the medical profession. Consideration is being given to other ways of using survey results as a basis for formulating association strategies and programs.

2. *Development of a closer relationship between OSMA and medical students.* This past year the council initiated a Student Communications Program designed to establish better lines of communication between OSMA and medical students and to generate student interest in becoming active members of the association. OSMA staff worked with faculty and students at the University of Oklahoma College of Medicine to develop a series of roundtable discussions for first-year medical students. Discussion subjects were selected after consultation with students and were chosen partly because they covered information not ordinarily encountered by students in their studies.

The roundtable discussion included: "An Inside Look at Rural Medicine"; "How Hospitals Work"; "Physicians and the Legislative Process"; "Technology in Medicine"; "Opening a Medical Practice: Where Business and Medicine Meet"; and "Membership in the Oklahoma State Medical Association." Discussion leaders were drawn from the ranks of OSMA member physicians and staff. The roundtables were conducted over lunch at the Faculty House on the Health Sciences Center campus. Students were introduced to the series at an OSMA-sponsored picnic held in August at Will Rogers Park.

Feedback from students attending the series has been overwhelmingly positive, and faculty liaison Wilson D. Steen, PhD, says there is great interest among students in continuing the program during the next school year.

Student interest in joining the association has increased noticeably since the program was begun; student membership from Oklahoma County has grown by 17 to a total of 43. Although no formal program has been established for students in the Tulsa area, recruitment brochures and posters were distributed to both medical colleges there at the beginning of the school year. Since then, 11 new student members from Tulsa have been added to the association's membership roster. All new student members received a letter of congratulations from OSMA upon their acceptance by the county medical societies. When special events

are scheduled, such as the annual meeting or meetings of the OSMA Board of Trustees, an OSMA staff member sees that students are invited to attend and participate.

3. *Improvement of communication between physicians and their patients.* Council efforts to improve the physician-patient relationship have focused on established better two-way communication through the use of brochures, surveys, and other consumer-oriented publications.

A new series of *Medical Update* brochures published in 1982 has proven extremely popular with member physicians and their patients. The brochures covered four subjects: sound and sensible dieting; patient compliance in taking medications; hazards of overexposure to the sun; and dangers of frostbite. The brochures, which are distributed to member physicians free of charge, provide medical information to patients in a clear and concise form and encourage patients to discuss the subjects with their physicians.

Council members have approved the questions to be included in a patient survey designed to provide physicians with feedback from patients concerning areas of both efficiency and deficiency in their practices. Results of the opinion survey showed that satisfaction with physicians is influenced in part by factors that can be controlled by individual physicians, such as waiting time for an appointment, waiting time in the office, treatment by the physician's staff, and the physician's explanation of the patient's medical problems and recommended course of treatment. The patient survey will give physicians a better insight into how effectively their practices are operating and what, if any, changes need to be made.

The survey has been designed and typeset and will be printed and distributed following the annual meeting.

The council also has approved development of a prototype patient information booklet to serve as a comprehensive guide to physicians in preparing booklets for their own individual practices. The council will consider asking permission to reprint an excellent article describing how to develop a patient information booklet that appeared in the January/February 1983 issue of *Medical Group Management*. Using these reprints could save the considerable time and expense involved in developing a prototype booklet from scratch.

It should be noted that a portion of funds budgeted for these two projects in 1982 were

reallocated by the council to fund an important public service project; thus, the 1983-84 budget will include a funding request to cover printing costs for these projects. (The public service project is described in the next section of the report.)

In line with its efforts to foster better physician-patient communication, the council endorsed the efforts of OSMA staff to publicize the Patient Medication Instruction (PMI) program developed by the American Medical Association. PMI sheets contain information and instructions on commonly prescribed drugs and are designed to assist physicians in prescribing, and patients in taking, prescription drugs. No expense is incurred by OSMA in promoting the program, since the PMIs are printed and distributed by the AMA and are paid for by individual physicians.

4. *Sponsorship of public service activities:* Of the public service activities undertaken by OSMA recently, the most significant involves sponsorship of an anti-drunk driving film being produced by the Oklahoma Department of Public Safety and the Oklahoma Highway Patrol. Council members voted to approve the use of council funds for OSMA to become one of the film's ten sponsors.

Titled *None for the Road*, this docudrama will depict three different but typical stories that involve driving under the influence of alcohol (DUI). The film will cover the legal, social, and economic consequences of being arrested and/or being involved in an accident while driving under the influence. This will be the first film produced for the Oklahoma Highway Patrol dealing strictly with the DUI problem and the new state laws relating to this violation.

As a sponsor of this film, OSMA will receive prominent and positive name and logo screen credit on each of the 35 prints and all tapes distributed to television stations across the state. The Oklahoma Department of Public Safety has guaranteed in writing to show this film extensively throughout the state on television stations and before civic clubs, safety meetings, school classes, and other organizations for a period of not less than two years. The film is expected to be ready for distribution in June 1983.

Because of the early deadline for payment of OSMA's sponsorship fee, council members, with the concurrence of OSMA President John

A. McIntyre, MD, agreed to allocate funds for payment by deferring completion of several projects approved in the 1982 budget. The deferred projects included printing of the patient survey and prototype patient information booklet, production of radio public service announcements, and sponsorship of a reception for members of the media. Funds to complete some of these projects are requested in the 1983-84 budget.

In making the decision to fund the anti-drunk driving film, council members took note of recent statements and actions by the American Medical Association urging state societies to support and promote efforts to curb drunk driving, the nation's number one killer on the highways.

OBJECTIVES:

The Council on Professional and Public Relations has formulated a set of objectives designed to accomplish the goals stated earlier in this report. To achieve these objectives, the council requests that the activities listed in the recommendations section of the report be approved. A description of these objectives and recommended activities follows.

1. *Objective: Communicate to the public the benefits of developing healthy living habits and making informed decisions about medical care.* The council recommends that this type of information be conveyed in two ways — publicly by OSMA through a series of radio public service announcements (PSAs) and personally by physicians through a new series of *Medical Update* brochures.

Both the PSAs and the *Medical Update* brochures will advise consumers not only on ways to take better care of themselves but also on ways to help contain the rising costs of medical care. Subjects selected by the council for the radio PSAs include hypertension, frostbite (in season), impaired driving, and appropriate use of the emergency room. Subjects for the *Medical Update* brochures include proper emergency room use, adult immunizations, and appropriate uses for antibiotics.

2. *Objective: Continue to improve OSMA's relationship with medical students.* The council recommends that the Student Communications Program begun in 1982-83 at the University of Oklahoma College of Medicine be continued and expanded. The popularity of the program is evident from the consistent high attendance at the roundtable discussions and by requests from students to be included in subsequent

programs. Faculty liaison Wilson D. Steen, PhD, has praised the program and has expressed a desire to continue coordinating the program for OU students.

Because the number of students interested in last year's program greatly exceeded the number of slots available, those admitted to the program had to be chosen by lot. Expanding the program to include more students would heighten the association's visibility and, at the same time, increase student awareness of what goes on in organized medicine.

The council will consider the possibility of offering a similar program to medical students in the Tulsa area; however, this will be contingent on locating Tulsa-based physicians and educators willing to coordinate programs at the Tulsa schools. (Funds for a Tulsa-based student program are not being requested at this time.)

3. *Promote a better understanding within the medical profession of the medical needs of the aging.* The council recommends that a program be established to enable physicians to better understand the medical needs of the elderly in Oklahoma. This recommendation is prompted by actions of the Council on Planning and Development directing this council to appoint a special committee to meet with the American Association of Retired Persons (AARP) and other advocacy groups representing the elderly. Meetings will serve as a forum for the exchange of information, discussion of problems, and development of cooperative solutions for serving Oklahoma's elderly population. OSMA will sponsor a reception and/or dinner in conjunction with each scheduled meeting.

4. *Objective: Continue to enhance the association's image and contribute to the public's well-being through sponsorship of community service projects.* The council recommends that OSMA continue its financial support of community service projects, such as the Oklahoma Prevention of Child Abuse annual Easter party and summer swim party. OSMA receives favorable publicity through its sponsorship while providing a worthwhile service to those who benefit from the projects. The council recommends that OSMA select a maximum of four community service projects for 1983-84.

5. *Objective: Continue to foster better communication between physicians and their patients.* The council recommends that the patient survey and patient information booklet begun in 1982-83 be completed. The rationale for developing these publications is set forth earlier in this report.

6. *Objective: Promote the "stay well" bonus feature of the PLICO Health program.* The council recommends that OSMA initiate a PLICO "Stay Well" Bonus Congratulations Campaign to recognize PLICO Health subscribers who file no claims against their policies. To date, about 46 percent of PLICO policyholders have filed no claims and thus are eligible to collect their "stay well" bonuses. This low rate of utilization benefits all PLICO policyholders as well as the association.

The new campaign would generate publicity both within and outside of the association, reward bonus recipients with mementoes of their accomplishment (eg, lapel pins or pendants), and employ other appropriate means to encourage continued low utilization. The campaign will be funded by PLICO.

7. *Objective: Continue to provide OSMA members with up-to-date information on scientific, legal, and professional developments affecting the practice of medicine.* The council recommends that OSMA continue to publish the *OSMA Journal* and the *OSMA News* on a regular basis in order to keep members fully informed about key issues related to health care and the practice of medicine.

RECOMMENDATIONS:

Specific recommendations of the Council on Professional and Public Relations for the 1983-84 year, along with budgetary requirements, are as follows:

- A. Production of *Medical Update* brochures (3)\$1,300.00
- B. Production of radio public service announcements (4)\$3,500.00
- C. Conduct Student Communications Program\$2,000.00
- D. Establish program to improve relations with the elderly\$1,200.00
- E. Sponsor community service projects (4).....\$1,000.00
- F. Print and distribute patient survey\$1,750.00
- G. Print and distribute article on patient information booklet\$1,200.00
- H. Publish *OSMA News*\$5,000.00
- I. Educational activities and professional dues\$2,500.00
- J. The contingency fund established by the association several years ago and later earmarked for a campaign against passage of national health insurance totals about \$35,000. It is being held in an interest-

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bearing account. The council recommends that the fund continue to be held in the account.

Respectfully submitted,
M. Joe Crosthwait, MD, Chairman
Howard A. Bennett, MD
John Bozalis, MD
Jerry L. Bressie, MD
John R. Christiansen, MD
Richard Marshall, MD
Paul E. Massad, MD
Mary Anne McCaffree, MD
Houston F. Mount, MD
Thomas E. Nix, Jr, MD
Ralph Payne, Jr, MD
H. Craig Pitts, MD
Alvin Rix, MD
Armond Start, MD
Robert J. Weedn, MD
Kenneth W. Whittington, MD
Milton Workman, MD
Anita H. Delaporte, Staff

Report of the COUNCIL ON PUBLIC AND MENTAL HEALTH

SUBJECT: Annual Report

PRESENTED BY: Frank L. Adelman, MD,
Chairman

REFERRED TO: Reference Committee II

INTRODUCTION:

It is the goal of the Council on Public and Mental Health to provide the citizens of this state as well as OSMA members with timely information regarding the medical aspects of public and mental health and to conduct and oversee needed programs in these areas.

REVIEW OF ACTIVITIES:

The activities of the Council on Public and Mental Health for the 1982-83 year were largely determined by the report of the council which was approved by the House of Delegates in May 1982, and by the committees which operate under the council's guidance. The following is an update on the approved program for the Council on Public and Mental Health and the committees which operate with the council's direction.

A. Health Education — As we discussed in our report last year, the Oklahoma Health Education Advisory Council was successful in

getting legislation passed which allowed for the financing of several pilot projects for the teaching of comprehensive health education in several schools throughout Oklahoma. We can report that these projects have been graded highly and it is hopeful that the legislature will see fit to increase the number.

Recently, the Health Education Advisory Council informed us that new certification standards for health education teachers were being considered at a public hearing on April 15, 1983. The OSMA provided brief written testimony supporting the new curriculum for health education teachers.

B. Sports Medicine Committee — The newly reactivated Sports Medicine Committee of the OSMA, under the guidance of Joe B. Jarman, Jr, MD, Enid, held its first meeting in April. Much of the time was spent in developing and discussing goals and the objectives for the committee. The Oklahoma County Medical Society requested that the committee consider adopting a new, more comprehensive sports physical form to be utilized by the Secondary School Association. In order for the form to work properly, it will have to be placed in the child's school records so it can be maintained. This is different from the way sports health forms are handled at this time.

The committee also considered a resolution which was passed by the North Carolina State Medical Association concerning safety equipment in equestrian sports. The committee was not unanimously convinced that this type of resolution would do any good, but decided to introduce a similar resolution in order to not appear to be against safety measures in equestrian sports.

C. Nutrition Committee — During this past year, the Council on Public and Mental Health was approached by the leadership of the Oklahoma Dietetic Association to consider forming a joint OSMA/ODA Nutrition Committee. The goal of the committee was to improve the health status of Oklahomans and combat nutrition misinformation by increasing nutrition knowledge. Several objectives were outlined (1) review and disseminate up-to-date information to the membership of the OSMA and to the public; (2) provide resources for patient nutrition education; and (3) investigate nutrition courses and training now offered to medical students and make recommendations for updating. The council took this request under consideration and decided that it was an excellent idea. A committee was created which

included Frank Adelman, MD, council chairman; Mark R. Johnson, MD; Robert Whang, MD; and Bertha Levy, MD. The Dietetic Association also named three representatives from their association.

The committee has had one meeting and discussed the possibility of having nutrition-related articles printed in the *OSMA Journal*. They also plan to disseminate information concerning fad diets and other nutritional misconceptions. The committee has also introduced a resolution which is included in your handbook for consideration.

D. *Maternal Mortality Committee* — This committee is established by an Oklahoma statute and operates independently of our council and the association. A committee report is attached as an addendum.

RECOMMENDATIONS:

1. Approve the sports physical form which was discussed in the Sports Medicine Committee.
2. Support and follow through on the two resolutions introduced by this council.
3. Continue the activities of this council as outlined by this report.
4. Approve the requested fiscal note for this council.

BUDGET REQUESTS:

Council and Committee Meeting

Expenses\$1,000.00

Maternal Mortality Committee250.00

Other Council Programs and Internal

Educational Programs1,000.00

TOTAL \$2,250.00

Respectfully submitted,
Frank L. Adelman, MD, Chairman

Betty Conrad, MD

Gordon H. Deckert, MD

Sara DePersio, MD

Hayden H. Donahue, MD

John W. Drake, MD

Jodie L. Edge, MD

George B. Gathers, Jr, MD

Mark R. Johnson, MD

Mark A. Kelley, MD

Joan K. Leavitt, MD

Bertha Levy, MD

Patricia McKnight, MD

Kirk T. Mosley, MD

Edward K. Norfleet, MD

George W. Prothro, MD

David S. Sholl, MD

Adolph N. Vammen, MD

Robert Wienecke, MD

Report of the COUNCIL ON MEDICAL EDUCATION

SUBJECT: Annual Report

PRESENTED BY: William R. Smith, MD,
Chairman

REFERRED TO: Reference Committee II

INTRODUCTION:

The council shall study and make recommendations related to all matters of maintaining or improving the level of competency of physicians in Oklahoma, including but not limited to, maintaining liaison with the medical education colleges in Oklahoma, to conducting continuing medical education courses for association members, and to the accreditation of medical education programs in Oklahoma. It will also monitor continuing medical education standards as they may be required by association policy.

A. *Continuing Medical Education Survey and Accreditation Program* — The council continues its activities of surveying and certifying for accreditation the continuing medical education programs of hospitals over the state of Oklahoma. An extension of the Accreditation Council on Continuing Medical Education, the Oklahoma State Medical Association has the sole responsibility of approving such courses. At the present time, the following institutions are fully accredited to produce and cosponsor Category I Continuing Medical Education Programs:

Baptist Medical Center, Oklahoma City

Hillcrest Medical Center, Tulsa

Mercy Health Center, Oklahoma City

Presbyterian Hospital, Oklahoma City

South Community Hospital, Oklahoma City

St Anthony Hospital, Oklahoma City

St Francis Hospital, Tulsa

St John Medical Center, Tulsa

We have scheduled for this year two surveys and the prospects of an initial survey of Duncan Regional Hospital. It is still encouraging to find that the CME programs of these individual institutions are continuing to prosper on a voluntary basis.

B. *Statewide Continuing Medical Education Survey* — Because all of the accredited institutions in the state of Oklahoma are from the metropolitan areas of Oklahoma City and Tulsa, the council continues to be concerned that the rest of the state has access to the con-

tinuing medical education they need. In order to find out what those needs might be, the council did a statewide survey of all county medical society presidents and hospital chiefs of staff to see if their continuing medical education needs were being met. We then contacted all of the accredited institutions and their directors of continuing medical education to ask their support in working with any county medical society president or hospital which indicated that they were in need of more CME.

We were very satisfied in that we were not inundated with responses from people around the state indicating that they needed more CME; however, we did receive a number of requests for additional CME and we have acted as the go-between to place those communities in contact with an institution in either Oklahoma City or Tulsa which will be willing to assist them in receiving whatever CME they feel they need.

C. Liaison with Medical Schools — In an attempt to better understand how the OSMA might be of any assistance to the medical colleges in Oklahoma, and also to see how the colleges may assist us, a representative from the OSMA met with both Deans of the University of Oklahoma College of Medicine and the Tulsa Branch of the College of Medicine. We hope to continue this communication into this year and we hope that closer communication can be also made with the representatives from Oral Roberts University.

D. Reciprocity of CME Credits — Last year the House of Delegates considered and approved Resolution 12, which asks for this House to endorse a dual reciprocity system between the American Medical Association and the American Academy of Family Physicians, concerning their CME credits. This resolution also instructed the OSMA House of Delegates to pass this resolution on to the AMA and the AAFP. Somehow this resolution was misplaced and was never sent to the AMA nor the AAFP. Because this resolution has already been adopted by this House, adoption of this report will reinstruct this council to send this resolution to the AMA and the AAFP this year.

RECOMMENDATIONS:

1. The OSMA continue to actively survey and resurvey institutions for continuing medical education accreditation.
2. The OSMA continue in its support and

open communication with Oklahoma medical schools.

3. The council continue to send representatives to local, state, and national meetings when appropriate.

BUDGET REQUESTS:

Accreditation surveys	\$1,000.00
Educational requirements	2,000.00
TOTAL	\$3,000.00

Respectfully submitted,
William R. Smith, MD, Chairman
John R. Alexander, MD
Irwin H. Brown, MD
Robert J. Capehart, MD
John W. Drake, MD
David Hinshaw, MD
Thomas N. Lynn, Jr, MD
Charles B. McCall, MD
Harris J. Moreland, MD
Arnold G. Nelson, MD
Lawrence W. Patzkowsky, MD
Lenard A. Poplin, MD
Jack M. Stephenson, MD
Lowell N. Templar, MD
Edward J. Tomsovic, MD
Hal B. Vorse, MD

Report of the COUNCIL OF MEDICAL EDUCATION

SUBJECT: Health Manpower Surveillance
Committee

PRESENTED BY: Thomas N. Lynn, Jr, MD,
Chairman

REFERRED TO: Reference Committee II

During the November 1982 Board of Trustees Meeting, John McIntyre, MD, President, was instructed to create a special committee to study the medical population of Oklahoma and to determine if we were producing too many physicians, not enough physicians or just the right number of physicians.

The committee held its first meeting in February to identify exactly what its charge was and how to go about meeting that charge. It was the consensus of the committee that it would require several meetings and the study of a considerable amount of information in order to finalize a position to be recommended to the OSMA Board of Trustees.

At this time, the OSMA, through the data system of the Foundation for Peer Review, controls the most up-to-date and complete data

base on Oklahoma physicians. However, this information was not available at the time of the first meeting and until the committee has access to some raw data, their first action was to recommend to the Board of Trustees during their February meeting that:

"For the time being, the number of students entering all medical schools in Oklahoma be *maintained* at this year's current level until a thorough study can be completed and a position formalized as to whether we are producing the appropriate number of physicians for Oklahoma."

This recommendation was approved by the Board of Trustees at their February 27, 1983 meeting.

Since the last meeting of this committee and the Board of Trustees meeting in February, the physician data for Oklahoma has been released to the committee for this review. At the time of this writing, the committee has scheduled another meeting prior to the meeting of this House. If something of great importance concerning the production of physicians in Oklahoma is decided at their next meeting, it will be reported to the Board of Trustees at their meeting on May 4, 1983.

Respectfully submitted,
Thomas N. Lynn, Jr, MD, Chairman
David Hinshaw, MD
Charles B. McCall, MD
Harris J. Moreland, MD
Arnold G. Nelson, MD
William R. Smith, MD
Lowell N. Templer, MD
Edward J. Tomsovic, MD

Report of the COUNCIL ON MEMBER SERVICES

SUBJECT: Annual Report
PRESENTED BY: Elvin M. Amen, MD,
Chairman
REFERRED TO: Reference Committee II

INTRODUCTION:

This Council is responsible for monitoring and developing programs that offer direct benefits to physicians as a result of their membership in the Oklahoma State Medical Association. These include a variety of sponsored insurance programs — including the successful professional liability coverage through PLICO, PLICO's Health Insurance, Group Life Insurance, Hospital Indemnity Insurance, Disability

Income Insurance, full time accident insurance, business overhead expense insurance, and a disability insurance program for student members. The Council supervises the OSMA-sponsored tours and offers numerous other programs each year for OSMA members. In addition, the Council is available to assist county medical societies, the OSMA Auxiliary, and resident and medical student organizations.

REVIEW OF ACTIVITIES:

Selected Laws: Although published in 1982, the Council's *Selected Oklahoma Medical Statutes* booklet is still being given out in great quantities. This booklet is available to any OSMA member or PLICO insured free of charge upon request. It is also being automatically sent to all new members of the Association. Thus far over 3,500 copies have been distributed.

The book is also available for sale at a cost of \$10 per copy to nonmembers and to other interested persons.

NEW EMPLOYEE SEMINARS:

A series of seminars for new medical office employees was sponsored by the Council in 1982 and '83. The purpose of the seminars is to familiarize new medical office employees with the legal and ethical aspects of the doctor-patient relationship and to give them some background information on medical education, medical ethics, physician-hospital relationship, financing medical care, and working with patients.

In 1982 seminars were held on June 26 and September 25 in Oklahoma City and May 22 and September 11 in Tulsa. In 1983 programs were held on April 20 in Tulsa and April 21 in Oklahoma City. Ed Kelsay, Anita Delaporte, and Lyle Kelsey of the OSMA staff served as instructors for the seminars.

A fee of \$50 per person was charged to offset the cost of the seminars and to pay for the educational materials that were distributed.

CASSETTE TAPE:

A special 60-minute cassette on professional liability loss prevention was prepared in 1982 by Ed Kelsay, OSMA Legal Counsel, for distribution to association members and PLICO insureds upon request. The association has now exhausted its original supply of 1,000 cassettes.

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The Member Services Council, in conjunction with the PLICO Loss Prevention Committee, has authorized the creation of a new cassette program for distribution in early Fall, 1983.

The first program was broken down into two 30-minute presentations. Side one contained a general presentation on loss prevention for physicians, while side two was an in-depth discussion of informed consent.

The new cassette will contain similar, but updated, information. One side will be a presentation by Ed Kelsay entitled, "What Are You Going To Fill The Hole With?"

POSTERS:

A series of four professional liability prevention posters has been prepared and distributed to physicians' offices and hospitals in the last year. Three of the posters are designed specifically for hospitals, while the fourth may be utilized by either a hospital or a doctor's office.

PLICO LOSS PREVENTION:

The OSMA has a contract with PLICO to conduct loss prevention educational programs throughout the state. Ed Kelsay, staff legal counsel, has conducted nearly 300 such sessions since PLICO became operational in January, 1980. He has spoken to hospital medical staffs, county medical societies, and specialty societies, and has personally addressed over 3,000 medical doctors in the state. In addition, he has arranged for special guest speakers to appear before the Oklahoma and Tulsa County Medical Societies and eight specialty organizations.

In the summer of 1982 a series of six loss prevention seminars was conducted throughout the state of Oklahoma. Any physician who attended one entire program was eligible to receive a 5% per year premium discount for three consecutive years. Nearly 2,000 Oklahoma physicians avail themselves of this service.

Four additional programs are scheduled for the summer of 1983, two each in Tulsa and Oklahoma City. The same premium discount offer will be available to any physician attending one of the programs.

The Council also supervises the publication of the *PLICO News* quarterly in order to keep physicians up to date on professional liability activities.

Over 7,000 copies of the booklet *Professional*

Liability Medical-Legal Guide for Physicians have now been distributed to Oklahoma doctors. In addition nearly 4,000 copies of a one-page handout for allied health care personnel have been distributed throughout the state.

PLICO

PLICO, the Physicians Liability Insurance Company, reports separately to the OSMA House of Delegates.

PLICO HEALTH:

The report regarding this insurance activity of the Association will be included with the PLICO report.

COMPUTER CONFERENCE:

On April 13 your Council participated in the Southwest Computer Conference by offering a half-day program on the use of a computer in a medical office. The conference was actually three days long, April 12-14, in Oklahoma City's Myriad Convention Center and featured over 200 exhibits from computer hardware and software companies.

OSMA's portion was conducted on Wednesday afternoon by Ed Kelsay, OSMA Legal Counsel, and Jerry Kelly, Executive Director of the Oklahoma Foundation for Peer Review.

In keeping with the Council's policy of attempting to make each program self-sustaining, a fee of \$25 per person was charged.

PHYSICIANS COMMITTEE:

This special committee continues to be available for consultation with members of the Association who have personal problems that require discreet professional advice. The committee was established in the Bylaws of the Association approximately seven years ago. Any physician member of the Association may request assistance from the committee or the committee may receive recommendations from other Association committees, councils, physician members, or component societies, and may offer to counsel with a physician member. All counseling sessions are considered privileged and no formal written records are maintained on the committee's activities.

COLLECTION AGENCY ENDORSEMENT:

During the past year this Council was approached by two different national organizations specializing in the collection of past due accounts for associations: IC Systems and National Revenue Corporation.

Both companies wanted the Association to

"approve" their system for marketing directly to OSMA members. Neither was asking for the Association to "endorse" or "sponsor" their company. They both stated it was simply their wish to be able to tell physicians that the program was "approved" by the Association.

While the Council was favorably impressed with both companies and their approach to collecting past due accounts and felt that they could be entrusted with medical collecting, the Council determined that it did not wish to take any action on either request. Basis for this was the feeling that simply "approving" any company would be tantamount to an endorsement.

UNDERWRITING COMMITTEE FUNCTION:

This Council also serves as the Underwriting Committee for PLICO. During the past year it has heard and acted on approximately 12 underwriting problems and made appropriate recommendation to the management company for PLICO.

GROUP PURCHASE PLANS:

During the past year the Council approved one group purchase plan for OSMA members through the IBM Company. A special typewriter discount sale program was conducted to offer all members of the Association an opportunity to buy one of two different IBM typewriter models at a substantial discount. Approximately 53 association members availed themselves of the opportunity.

The Council now has pending for consideration a similar proposal by Xerox Corporation. While this plan was received in early April and has not yet been considered by the Council, it is similar to the IBM plan.

WORKERS COMPENSATION INSURANCE:

During its last meeting the Council received a proposal from the Dodson Insurance Group to offer Workers Compensation insurance to OSMA members at a reduced premium. The Council was favorably impressed with the Dodson proposal and has recommended that it be approved for sponsorship by the OSMA Board of Trustees.

There was some concern among Council members that there are still physicians in Oklahoma that do not realize that they are required to carry workers compensation insurance on their office employees. The change was made in Oklahoma's compensation law a few

years ago that extended the coverage to "all" employees . . . no matter how large or small the company.

OSMA SPONSORED INSURANCE: Life Insurance:

At the present time OSMA sponsors a life insurance program through Massachusetts Mutual Company. However, during its last meeting, the Council heard a proposal from the Continental Insurance Corporation for a new group term life insurance plan. The Council was favorably impressed and has recommended to the OSMA Board of Trustees that the new plan be adopted to replace the Massachusetts Mutual policy.

The Continental Corporation, through its subsidiary Loyalty Life Insurance Company pledged that it would pick up all of the insureds currently holding Massachusetts Mutual policies without requiring a medical examination. In addition they would also modify their benefit package so that no current insured would see any major change in the premium being paid. However, they would offer to upgrade the Mass Mutual policy to the higher limits offered by the Continental.

One other advantage of the Continental policy over the Mass Mutual is that the benefit remains level until age 70 for the insured. The Mass Mutual policy began rapidly decreasing its benefits at age 65, a situation which caused at least one physician's family in Oklahoma to discover they had far less insurance than they thought.

Accidental Death Insurance:

This OSMA program is written through Continental Insurance and provides benefits from \$25,000-\$100,000 for accidental loss of life, and a portion thereof for accidental loss of limb, eye sight, speech, or hearing. It provides 24-hour protection for the insured. At the present time 298 OSMA members participate in this insurance program.

Hospital Indemnity Insurance:

Also written by Continental Insurance Corporation, this program pays a specified amount per day whenever an insured is a patient in a hospital. The program will pay up to 365 days benefit of from \$20 to \$100 per day. It can be written to include the physician member, the spouse, and family. At the present time this program is utilized by 201 OSMA physician members and has paid out approximately

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\$18,000 in benefits since the program's inception.

Office Overhead Expense Insurance:

This coverage is written by Combined Insurance Company of America and is available to assist a physician who finds himself disabled by either sickness or injury and helps him pay his office overhead. The policy pays benefits to cover up to 100% of the overhead expenses of operating an office during the period of disability.

Benefits are available in increments of \$100 up to a \$3,000 a month maximum. Coverage is extended for up to 18 months, giving the disabled physician a time to close his office, if he wishes, or keep it open until he can return to duty.

Generally the premiums paid for overhead expense insurance are a tax deductible business expense and benefits, when paid, are usually tax deductible.

At the present time there are 225 OSMA members utilizing this program.

Student Disability Income Insurance:

This is a special program available to medical students through the Association. The program pays up to a maximum of \$100 per week whenever a student is disabled and includes a \$1,000 accidental death benefit. In addition, it pays from 100 to 200 times the weekly benefit for accidental loss of limbs, sight, speech, or hearing. It pays a minimum lump sum amount for specific fractures and dislocations and benefits are payable regardless of other insurance.

This policy is marketed directly to medical students.

Disability Income Insurance:

During its February meeting the Council authorized an updating of the Association's disability income program to a newer policy with higher benefit limits. This program is also underwritten by Continental Insurance companies through its commercial insurance company of Newark, New Jersey. There are three benefit levels within the program, and each physician chooses the plan that he wishes. Plan L-65 has accident benefits payable for life and sickness benefits payable up to age 65. Plan L-7 has lifetime accident benefits and sickness benefits payable for a 7-year maximum, while

Plan 5-2 has accident benefits payable for 5 years and sickness benefits payable for 2 years.

Under the new disability plan, approved coverage can be purchased up to \$3,000 per month and a \$50,000 accidental death and dismemberment coverage.

At the present time 455 OSMA members are insured through this program.

SPONSORED TOURS:

For many years the OSMA has sponsored tours through the INTRAV Corporation. This is one of the most respected tour operators in the United States and it works primarily through associations and, more specifically, professional associations such as the medical, bar, bankers, etc.

In 1982 the Association sponsored four summer tours (Alpine Adventure, Nile River Adventure, Rhine River Adventure, and Scandinavian Adventure), two fall tours (China Adventure and European Capitals Adventure), and five tours in the spring of this year (Adventure Tours to Australia, the Caribbean, Jamaica, South Africa, and the West Indies).

Each tour is made up from several different states and usually contains an excellent cross section of other professionals.

Three tours are scheduled for the summer of 1983 (Canyonlands Adventure, Dutch Waterways Adventure, and Maine River Adventure) with an additional two scheduled for the fall (Colonial South Adventure and Danube River Adventure).

The Association recovers all of its expenses for promoting these tours from INTRAV Corporation and thus is able to make them available to Association members at no cost to the organization.

Respectfully submitted,
Elvin M. Amen, MD, Chairman
Richard A. McKinne, MD, Vice-Chairman
William G. Bernhardt, MD
William O. Coleman, MD
Joe Ray Hamill, MD
Joe S. Hester, MD
James S. Jones, MD
Robert A. McLauchlin, MD
Ross Rumph, MD
E. Edwin Fair, MD
Paul O. Shackelford, MD
George H. Jennings, MD
Jack P. Myers, MD
C. E. Woodard, MD
Ralph L. Buller, MD

**Report of the
OKLAHOMA STATE MEDICAL
ASSOCIATION AUXILIARY**

SUBJECT: Annual Report
PRESENTED BY: Betty J. Edge, President
REFERRED TO: Reference Committee II

Dr Long, Dr Jirka, Dr McIntyre, members of the House of Delegates, distinguished guests:

In many ways it seems like only yesterday that I stood before you as the incoming president of the OSMAA, yet a year has passed and shortly you'll be introduced to our new president. I would be remiss if I did not add, this has been an exciting, full, and enriching year in my life.

Allow me a few minutes to relate some of the auxiliary's accomplishments and activities of this past year.

First, we have increased our membership; currently we have 1,333 members. Our RP-MSS program is alive and well with 52 members and a potential for growth in the years to follow. In fact, one of our members from Tulsa has been contacted by National to serve in this area.

Our Nurse's Loan Fund has aided eight potential nurses this year, loaning a total of \$6,550.00. In fact, since its inception in 1949, a total of 242 students have received loans. Of these, 199 have paid in full for a total of \$62,468.50 plus interest.

Through innovative fund raisers, we will this year be contributing \$21,914.58 to AMA-ERF and thus to our medical schools. Next year we will be participating with the Alumni Association and school to channel funds into a scholarship for needy students.

And, what about our county auxiliaries, how are they faring?

Currently, we have 16 organized counties with a 17th coming into being in Altus.

Three of our auxiliaries are involved in the Hospice concept, raising funds and volunteering their time and efforts for this needed project.

Participation by auxiliaries in health fairs, setting up seminars and information regarding Teenage Suicide and Hygiene, raising \$2,500 for a self-help program to prevent child abuse, volunteering for eye-screening clinics, purchasing a Poison Index for a hospital emergency room, contributing funds towards the purchase of a kidney dialysis machine, and

offering loans and grants to health science students are but some of their projects.

Legislatively, we have fought against 18-year-olds buying beer and have sought to strengthen legislation so that all tots will be buckled in properly.

This year we sought to better inform ourselves regarding organ donation and its ramifications. E. N. Scott Samara, MD, director of the Organ Retrieval System of Oklahoma, spoke to us on this vital issue and we responded by participating in National Organ Donation Awareness Week, seeking to raise public awareness regarding this subject.

In closing, I want to say that I consider it a privilege to have served as state president of the Oklahoma State Medical Auxiliary; I thank them for giving me this opportunity and on their behalf, we thank you, the State Medical Association, for your support and encouragement of us in our undertakings.

I want to publicly thank my patient husband who has always encouraged me, but even more so this year while I put our daily life on 'hold'! Not only did he respond graciously, but he sold many raffle tickets for me, *unasked*; "greater love hath no man."

One other item; I would like to encourage you to visit the bronze exhibit tomorrow in the lobby entrance. Should you order or purchase any of these magnificent pieces displayed, Mr Riley, the creator, will donate 15% of the sale price to our Nurse's Loan Fund. And, by all means, stop and purchase tickets for chances on our raffle to be drawn Friday eve.

**Special Report of the
OKLAHOMA FOUNDATION FOR
PEER REVIEW, INC.**

SUBJECT: Annual Report
INTRODUCED BY: Raymond L. Cornelison,
Jr, MD, President, Midwest City, Oklahoma
Foundation for Peer Review
REFERRED TO: Reference Committee II

During the past year the Oklahoma Foundation for Peer Review has continued to carry out the tasks of a Professional Standards Review Organization using the review concepts developed under the Oklahoma Utilization Review System known as OURS. This past year the Foundation strengthened certain aspects of the program. One area was the initial use of a new status called "Exempt Status." This new

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status allowed certain hospitals in the state who have had an excellent track record to eliminate concurrent review entirely. Approximately 18% of the hospitals were included in the exempt category this past year. The Foundation anticipates that the percentage of hospitals on the exempt status will rise to 25% during 1983-84.

In order for the Foundation to give its Regional Review Teams better information with which to make their decisions, the Foundation utilized reports which were based on Diagnostic Related Groups (DRGs). These reports were used to adjust for the casemix of hospitals and physicians when making status decisions. They were used in such a way that an individual hospital's casemix could be compared to another hospital's or the state as a whole. The Foundation will continue to expand on the use of DRG casemix analysis in the future, especially in light of legislative changes which will affect all Oklahoma hospitals.

The Foundation also began using a special criteria known as the Alternate Evaluation Plan (AEP). This criteria allows the staff to bring more accurate medical chart information to the Regional Review Teams during their meetings. The Regional Review Teams have already found this information to be quite helpful in their deliberations.

During 1982 the Foundation underwent another evaluation by the US Department of Health and Human Services. The results of the evaluation placed the Foundation within the top 15% of PSROs in the country who were being evaluated. However, while the evaluation was being carried on nationally, the Department of Health and Human Services abandoned the evaluation when the Government Accounting Office demonstrated several biases in the evaluation tool. Since that time all evaluations have been discontinued and no new evaluations have been scheduled.

On the legislative front, the US Congress passed two laws, signed by the President during the last year, which directly affect the operations of the Oklahoma Foundation for Peer Review. The Tax Equity and Fiscal Responsibility Act of 1982 reinforced the position of physician peer review organizations throughout the country and significantly redesigned the administration of the program. In the future there will be utilization and quality control peer review organizations (PROs) which

will contract with the Department of Health and Human Services. These contracts will be for a period of two years rather than one and will be far more flexible than those under the PSRO program. In addition, the Social Security/Prospective Payment Act of 1983 made some slight changes to the new peer review organization program, namely, that the program will no longer be subject to the appropriations process. The new contracts will require that the peer review organizations review utilization and quality under the prospective payment system to be based on Diagnostic Related Groups (DRGs). The Board of Directors of the Foundation are looking very closely at this new payment system and its effect on the Foundation's operation in the future. No regulations have been published on this new system at this time.

The Foundation continues to contract with the Oklahoma Department of Human Services for utilization and quality review. This contract was renewed in January 1983 and runs through the end of the calendar year.

The Foundation also initiated a utilization review program with several companies in the Tulsa area. The new private utilization review program was begun on March 1, 1983, in seven Tulsa area hospitals. Some eight companies were involved during the initial month of the program. The Foundation expects several other companies to join the program in the near future. The program was initiated in conjunction with a group known as the Tulsa Business/Medicine/Hospital Coalition in Tulsa. The Foundation has just contacted private health insurers who are also interested in the program. The review program continues to follow the basic philosophy of the OURS program.

Report of the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

An Addendum to the Report of the
Council on Professional and
Public Relations

SUBJECT: Annual Report
PRESENTED BY: Mark R. Johnson, MD,
Editor
REFERRED TO: Reference Committee II

The Journal of the Oklahoma State Medical Association continues to be one of the most

popular, tangible benefits of membership in the association. Its breadth of scientific information, along with timely news reports of OSMA activities and developments in the legal, political, and professional arenas, provides a wealth of knowledge for the physician members of the association.

Some design changes were made in the *Journal* this past year to improve readability of the lengthy articles, and closer attention was given to editing the articles. When the *Journal* was entered in the Sandoz Medical Journal competition, these improvements were recognized by the judges, who awarded the *Journal* an "Honorable Mention" for excellence in design and editorial content. It is hoped that further improvements will be made in the coming year.

The series on "Leaders in Medicine" will continue to be a feature in selected issues. These articles focus on Oklahoma physicians who have made significant contributions to medicine in the state and, in the opinion of the Editorial Board, deserve to be recognized for their accomplishments.

Winners have been selected by the Editorial Board to receive the \$500 Charlotte S. Leebron Memorial Trust Award and \$100 Sandoz Pharmaceutical Company Journal Award. These awards are given by the board to authors of the year's best scientific articles published in the *Journal*.

Pending the approval of William Leebron, MD, both awards will go to Thomas and Renee Tinker, fourth-year medical students at the University of Oklahoma College of Medicine, for their article "An Analysis of Nutritional Knowledge in the General Public." The board agreed that since the authors have not attained the status of "physician" as provided for in the memorial trust, it would be necessary to obtain Dr Leebron's consent to give them the Leebron award. The awards will be presented during the annual meeting.

The Editorial Board also voted to increase advertising rates in the *Journal*, effective January 1984. The board decided to:

- charge the 3-time, black-and-white page rate for all 2-page inserts;
- charge the 5-time, black-and-white page rate for all 4-page inserts;
- if printing costs do not rise, increase all rates 5 percent;
- if printing costs do rise, increase rates 1½

times the percentage increase from the printer.

The Editorial Board recognizes the outstanding achievements and dedication of Louise Martin, who is retiring as editorial assistant after many years of service. She has served the association and the *Journal* with distinction, and she will be greatly missed. The board will work closely with her successor to ensure the continued high quality of the publication that was achieved under Mrs Martin's guidance.

Respectfully submitted,
Mark R. Johnson, MD
Editor-in-Chief

Harris D. Riley, MD
Editor

Robert G. Tompkins, MD
Editor

Solomon Papper, MD
Corresponding Editor

Report of the PERINATAL TASK FORCE

SUBJECT: Annual Report

PRESENTED BY: Hal B. Vorse, MD, Chairman

REFERRED TO: Reference Committee II

At the 1982 Annual Meeting, the House of Delegates voted to have a Perinatal Task Force established to address the needs of ill newborns in Oklahoma. In the interval, members of this committee met along with other interested individuals from over the state at Oklahoma Children's Memorial Hospital at the invitation of the neonatology service. Attached are minutes of those meetings and a list of those attending.

It is the intention of the Perinatal Committee to continue to study the issues concerning sick infants in Oklahoma and report regularly to the membership of OSMA through its House of Delegates and Board of Trustees.

The current issues that are seriously affecting the care of sick newborns across the state are those of availability of intensive care facilities and lack of adequate transport to existing facilities. Recommendations concerning these issues will be presented to the House of Delegates in the form of a separate resolution.

Respectfully submitted,
Hal B. Vorse, MD, Chairman
Mary Anne McCaffree, MD

William H. Simon, MD
Thurman Shuller, MD
Paul McQuillen, Jr, MD
James R. Rhymer, MD
George Giacoia, MD
Sara Reed DePersio, MD
Warren M. Crosby, MD

ATTACHMENT I

NEONATAL PLANNING SESSION
MINUTES

August 25, 1982

Oklahoma Children's Memorial Hospital

Dr Sara DePersio gave a report on 1981 statistics from the State Health Department. She indicated there might be a slight drop in the quality of care for both prenatal and neonatal services in certain counties. Dr Edd Rhoades said we could figure on about a 5% growth rate per year, statistically.

Dr Ray Cornelison indicated a need for learning methods whereby we can do something about the problems of insufficient prenatal care.

Dr Bob Hill presented a table of statistics for prenatal care in Oklahoma. He said that Family Medicine has been trying to take on two Gyn-Ob specialists, but hasn't done so yet.

Dr Warren Crosby stated that the problem lies in inadequate prenatal care. The need is critical for adequate care in this area.

Dr Paul Toubas described some of the problems encountered at Oklahoma Children's Memorial Hospital when a referral comes in. Major problems are time delays looking for bedspace, transport delays, and geography.

Dr Mary Anne McCaffree presented projected needs for neonatal services in Oklahoma. Based on current need, eleven additional ventilator support beds are needed.

Ann Darling explained the Mediflight Program, a service of Oklahoma Teaching Hospitals. She indicated that there are problems because the receiving hospital must accept financial responsibility for payment of the transport bill. This may create negative attitudes among administrators concerning acceptance of transfers. Dr William Simon indicated that Enid won't take a patient by Mediflight even if a bed is available because of the financial responsibility for transport.

Dr Blalock gave a report of growth and demand for services at Mercy. They have had a five-fold growth in the last three years in obstetric services. In their NICU, 90% are inborn, which limits their ability to take referrals.

Dr Ray Cornelison said that DHS needs to be made aware of the problems created with payment to Mediflight and how it is hindering progress in providing services.

Dr Leroy Mims addressed some of the problems they are encountering in Tulsa, with all the hospitals being private institutions. Major problems are created by DHS and the possible limitation of 10 days' care on Title XIX. Patients after 10 days will need to be moved, as hospitals cannot afford to operate without payment. He said that Hillcrest has facilities and staff for a Level III nursery, but no administrative approval because of no DHS support. He indicated that St John's prefers maternal transports over neonatal. They turn down about two neonates a week.

Dr Gary Floyd addressed the problem of hospitals in central Oklahoma not being equipped to handle the needs presently.

Dr Tawfik Ramadan indicated that Ada is taking care of their area, but they are having the same problems with Title XIX and staffing. They can accept short term respirator transfers, but not long term.

Dr Ed Legako gave a report from the Lawton area. Their need is great for training for current staff and upgrading nursery staff. They are trying to get a new hospital wing built.

Dr Jim Mays reported from Presbyterian that they are sending their patients out of state because of unavailability of beds. Presbyterian attempted to begin a cooperative effort with OUHSC/OTH, but this was refused by the Dean. They feel the need for some sort of cooperative effort with other hospitals. They have bedspace available for five respirators but no neonatal care available.

Dr David Kallenberger reported from Baptist. They currently have from 125 to 150 deliveries per month. He expressed the need for training for general pediatricians in handling neonates, and that this would help bridge the gap. Perhaps a consult would save an NICU bed by allowing the infant to be cared for in the delivering hospital.

The American Academy of Pediatrics has taken a stand that ventilator support needs to be done by a neonatologist and not a general pediatrician. Dr Blalock suggested that this be reconsidered in Oklahoma — that many

pediatricians have experience and ability in this sort of care.

Dr Mary Perez gave a report on the OMH nursery and their method of triage. They are experiencing overcrowded conditions, like everyone else. OMH admits maternal patients only, not neonates.

An ad hoc committee was formed to meet together and come up with strategies for the next steps to meet the goals stated. Members of this committee are: Leroy Mims, MD, Bill Simon, MD, Ed Legako, MD, Sara DePersio, MD, and Mary Anne McCaffree, MD.

Another meeting will be scheduled after the ad hoc committee meets. Total attendance at this meeting was 33 people.

SUMMARY

Problems Addressed:

1. More babies being born.
2. Quantity/Quality prenatal care inadequate.
3. Delays in transfer when time is of essence in saving life.
4. Space unavailability.
5. Transport restrictions because of economics.
6. Funding restrictions—Title XIX.
7. Staff shortages.

Solutions:

Short Term

1. Transport funding.
2. More "back" transport.
3. Level II triage.
4. Plan with administrators.
5. Talk with DHS regarding Title XIX.
6. Improve hospital services.
7. Triage patients to other systems available (ie, military if patient is military personnel).
8. Triage centralized—bed bank (creates a need for new facilities and people to do it).
9. Training for existing staff (program already exists—CME).

Long Term

1. Prenatal prevention.
2. Expansion of services.
3. Regionalize care in the state.

NEONATAL PLANNING SESSION

August 25, 1982

Joe Alexander, MD, Mercy Health Center, Oklahoma City

William Bernhardt, MD, Oklahoma Academy of Family Practice, Oklahoma City

Robert Blalock, MD, Mercy Health Center, Oklahoma City

Jack Boyd, Oklahoma State Health Planning Commission

Delta Bridges, Jr, MD, McAlester General Hospital, McAlester

John Byrne, Administrator, Oklahoma Children's Memorial Hospital

Ray Cornelison, MD, Oklahoma County Medical Association

Warren Crosby, MD, OUHSC Department of Obstetrics

Ann Darling, Mediflight Director, Oklahoma City

Larry D'Angelo, MD, St Francis Hospital, Tulsa

Sara DePersio, MD, Maternal & Child Health, State Health Department

Gary Floyd, MD, Central Oklahoma Pediatric Society

Robert Herndon, MD, Oklahoma Chapter, American Academy of Pediatrics

Robert F. Hill, PhD, OUHSC Department of Community Medicine

David Kallenberger, MD, Baptist Medical Center, Oklahoma City

Edward Legako, MD, Comanche County Hospital, Lawton

Mary Anne McCaffree, MD, Oklahoma Children's Memorial Hospital, Oklahoma City

Gary McGann, MD, Presbyterian Hospital, Oklahoma City

Leroy Mims, MD, St John's Hospital, Tulsa

Mary Perez, MD, Oklahoma Memorial Hospital Nursery, Oklahoma City

Richard Polk, DO, Oklahoma Osteopathic Association, Tulsa

Tawfik Ramadan, MD, Valley View Hospital, Ada

Chris Ramsey, MD, OUHSC Department of Family Medicine

Edd Rhoades, MD, State Health Department, Oklahoma City

Cleveland Rodgers, Oklahoma Hospital Association

Roger E. Sheldon, MD, Oklahoma Children's Memorial Hospital, Oklahoma City

William H. Simon, MD, St Mary's Hospital, Enid

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Paul L. Toubas, MD, Oklahoma Children's Memorial Hospital, Oklahoma City
Hal Vorse, MD, Oklahoma State Medical Association
J. B. Wallace, MD, Valley View Hospital, Ada

SECOND OKLAHOMA NEONATAL PLANNING SESSION

March 3, 1983

Attendees

Joe Alexander, MD, Mercy Health Center, Oklahoma City
Sister Mary Alveria, President, Mercy Health Center, Oklahoma City
Henry Bellmon, Director, Department of Human Services
William Bernhardt, MD, Oklahoma Academy of Family Practice
Jack Boyd, Oklahoma State Health Planning Commission
John Byrne, Administrator, Oklahoma Children's Memorial Hospital
Chris Carey, MD, Department of Obstetrics/Gynecology, OUHSC
Greg Cox, Administrator, Mercy Health Center, Oklahoma City
Ann Darling, Director, Mediflight, Oklahoma City
Sara DePersio, MD, Maternal & Child Health, State Health Department
Kenneth Evans, MD, President-Elect, Oklahoma Academy of Family Practice
Gary Floyd, MD, Central Oklahoma Pediatric Society
George Giacoia, MD, Eastern Oklahoma Perinatal Center, Tulsa
Donald B. Halverstadt, MD, Executive Director, Oklahoma Teaching Hospitals
Albert Harvey, DO, Hillcrest Osteopathic Hospital, Oklahoma City
Robert Herndon, MD, Oklahoma Chapter, American Academy of Pediatrics
Robert F. Hill, PhD, Department of Community Medicine, OUHSC
Bertha Levy, MD, Associate Director, Medical Services Administration, DHS
Dick Lorenz, Oklahoma State Health Department
Mary Anne McCaffree, MD, Director, Neonatal Intensive Care, OKC Children's
Gary McGann, MD, Presbyterian Hospital, Oklahoma City

John McIntyre, MD, President, Oklahoma State Medical Association
Charles Mettry, MD, Valley View Hospital, Ada
Leroy Mims, MD, St John's Hospital, Tulsa
Tawfik Ramadan, MD, Valley View Hospital, Ada
Owen Rennert, MD, Chairman, Department of Pediatrics, OUHSC
Edd Rhoades, MD, Oklahoma State Health Department
Cleveland Rodgers, Oklahoma Hospital Association
Roger E. Sheldon, MD, Chief, Neonatal Section, OUHSC
William Simon, MD, St Mary's Hospital, Enid
William Thurman, MD, Chairman, Neonatal Committee, OKC Children's
Thomas Thurston, MD, Norman Municipal Hospital, Norman
Paul Tietze, MD, Department of Family Medicine, OUHSC
Paul L. Toubas, MD, Director, Neonatal Outpatient Clinic, OKC Children's
Hal Vorse, MD, Oklahoma County Medical Society
J. B. Wallace, MD, Valley View Hospital, Ada
James Wight, MD, Valley View Hospital, Ada
Robert Wright, Vice-President, Mercy Health Center, Oklahoma City
Pankaja S. Venkataraman, MD, Department of Neonatology, OUHSC

NEONATAL PLANNING SESSION MINUTES

March 3, 1983

Oklahoma Children's Memorial Hospital

The meeting was called to order and the attendees each introduced themselves. Minutes of the August 25, 1982, meeting were read and approved.

Dr William Simon reported on the progress of the Ad Hoc Committee to evaluate the clarification of the 10-day hospitalization guidelines and transport.

Clarification of the 10-day hospitalization was stated in a letter from Dr Levy to hospital administrators. Accessibility of transport for those patients who are being referred to hospitals without a contract with Mediflight is still highlighted as a problem.

The Interim Report entitled "Oklahoma Neonatal Services" was reviewed by Dr McCaffree. This report gives an overview of current ventilator services available along with pro-

posed additional services to meet the needs of the state. Each of the hospitals commented on the number of patient referrals that were diverted, the total number of admissions, and the number of patients from out of state who were either admitted or diverted from their unit.

Henry Bellmon, Director, Department of Human Services, was introduced by Dr Simon. Mr Bellmon reported on the decrease in sales tax revenues and other fiscal problems. He called upon Drs Halverstadt and Levy to make some comments regarding resources.

Dr Halverstadt's comments were primarily directed toward correspondence he had with Rep Cleta Deatherage. The need for infant care and transport is greater than current resources, with approximately \$1 million additional dollars needed to staff the currently empty 14 neonatal intensive care beds at OCMH. In addition, for a dedicated neonatal transport system (primarily helicopter) an additional \$1,600,000 would be needed annually. The average cost of a helicopter flight is \$1,600, he reported.

Dr Levy commented about transport, including back-transport of patients to hospitals of origin, and the February 23, 1983, letter that she sent to hospital administrators regarding payment for transport.

Mr Bellmon commented on the attempts being made to avert a decrease in benefits or services because of the decrease in revenues. Several items were suggested from the floor, such as an increase in sales tax, additional taxes on beer and tobacco, etc.

The concern about contractual agreements of hospitals with Mediflight for utilization of the transport system was reviewed. It was suggested that perhaps DHS should subsidize the transport system, or possibly a "hospital tax" be implemented to help fund the transport system. Mr Phil Fisher, hospital administrator from Ada, identified that the transport system was working well for them, because they approach transport as a necessary expense of participating in the care of these infants. He emphasized that rural communities need transport in order to care for sick newborns.

Dr Chris Carey indicated that the most efficient way to transport the high-risk neonate is within the mother, and that adequate obstetrical care would decrease the problem significantly. At Oklahoma Memorial Hospital in the past year, 3,600 deliveries occurred; 700 of those had no prenatal care. The perinatal mortality rate for the "no care" infants was 33.4

per 1,000 births, whereas those infants of mothers who received one prenatal visit had a perinatal mortality rate of 17.1 per 1,000. The ability to decrease the death rate by half by prenatal care will greatly decrease the problem of sick newborns. The program of preauthorization of maternal care by DHS should greatly help the problem of perinatal deaths.

Dr Sheldon questioned whether we should plan on taking care of infants delivered solely in the state of Oklahoma and limiting out-of-state admissions, or whether we should keep the frontiers open. It was the consensus that because of reciprocity we need to keep the borders open.

Methods of triage were discussed in an attempt to keep beds available for more critically ill patients. Weight category was discussed, as well as a transport mechanism utilizing a computer triage system to identify where beds were available.

Resources which were suggested to be evaluated besides the DHS and third party insurance companies included:

1. State and local health department facilities for prenatal care
2. Educational systems to decrease the intensity of the problems
3. Requests for funds in part from the private business sector
4. Line item appropriations from the legislature for items such as transport
5. Utilization of midwives and free clinics
6. Local foundations and fund raising groups

Dr McCaffree reported on the effect of the DHS reduction in force and planned furlough policy on the service availability at OCMH. The number of ventilator beds will be decreased from 13 to 11 because of staff shortages. Target date for the furlough policy is March 16. Dr Vorse asked if the neonatal units in the state could absorb the number of patients being referred to them because of this cutback, and the answer was negative.

The meeting was adjourned with a plan to bring the effect of the furlough policy on neonatal care to the attention of the Director.

Report of REFERENCE COMMITTEE III

PRESENTED BY: Thomas Crawford Alexander, MD, Chairman

Mr Speaker and Members of the House of Delegates:

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Reference Committee III considered the agenda items which were referred to it and submits the following report:

(1) REPORT OF THE COUNCIL ON GOVERNMENTAL ACTIVITIES

RECOMMENDATION:

Mr Speaker, Reference Committee III heard an excellent presentation of the Council report by Perry A. Lambird, MD. The Reference Committee would like to commend the Council on Governmental Activities and specifically Dr Lambird for the considerable amount of time devoted to the federal legislative process. Reference Committee III recommends that *the Report of the Council on Governmental Activities be adopted.*

(2) COUNCIL ON GOVERNMENTAL ACTIVITIES MEDICARE DEMONSTRATION PROJECT REPORT A

RECOMMENDATION:

Mr Speaker, your Reference Committee reviewed carefully the first draft of the Medicare Demonstration Project. The Reference Committee was aware of the tremendous amount of time involved with the development of this Medicare proposal. The Reference Committee would like to commend the Council on Governmental Activities and the OSMA Board of Trustees for their continuous study of this most interesting proposal. The Reference Committee recommends that *this project be scrutinized, refined, and submitted to the congressional delegation for consideration and, if the program is implemented, that it include acquiring demographic baseline medical data on participants.*

(3) REPORT OF THE COUNCIL ON STATE LEGISLATION

RECOMMENDATION:

Mr Speaker, your Reference Committee listened to considerable discussion about all of the activities in state legislation. Special commendation is given to Dr Bill Hughes for his effective leadership of this Council. The Reference Committee would like to make special mention of the White Paper and commend the Council for its development. Reference Committee III recommends that *the report of the Council on State Legislation be adopted and*

that copies of the White Paper be made available to OSMA members for use in educating their patients in the hazards of using unapproved medication and drugs.

(4) SENATE COMMITTEE PROJECT 89ers REPORT A

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Report A of the Council on State Legislation be filed.*

(5) SENATE AD HOC COMMITTEE ON MEDICARE REPORT B

RECOMMENDATION:

Mr Speaker, Reference Committee III recommends that *Report B of the Council on State Legislation be filed.*

(6) REPORT OF THE COUNCIL ON MEDICAL SERVICES

RECOMMENDATION:

Mr Speaker, your Reference Committee would like to commend the Council on Medical Services for a job well done, and recommends that *the Report of the Council on Medical Services be adopted.*

(7) MEDICAL ORDERS BY NON-MEDICAL PERSONNEL REPORT A

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Medical Orders by Non-Medical Personnel Report A be filed.*

(8) ASSIGNMENT OF INSURANCE BENEFITS REPORT B

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Assignment of Insurance Benefits Report B be filed.*

(9) REPORT OF THE OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends *adoption of the Report of the Oklahoma Medical Political Action Committee and urges all OSMA members to join OMPAC.*

(10) REPORT OF THE AD HOC COMMITTEE ON MEDICAL MALPRACTICE

RECOMMENDATION:

Mr Speaker, your Reference Committee heard the OSMA State Legislative Chairman indicate the status of the four bills prepared by the Ad Hoc Committee on Medical Malpractice and expresses appreciation for its completed work. The Reference Committee moves *adoption of the Report of the Ad Hoc Committee on Medical Malpractice and thereby concurs with the recommendation that this Committee be dissolved.*

(11) GRIEVANCE COMMITTEE REPORT

RECOMMENDATION:

Mr Speaker, your Reference Committee considered this report, and would like to suggest that when the Grievance Committee refers a case to the county society for adjudication that it also request a follow up from the county society as to the disposition of the case and when necessary the patient be informed of the appeal process through OSMA. Reference Committee III recommends *the Grievance Committee Report be adopted.*

(12) PHYSICIANS COMMITTEE REPORT

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends *adoption of the Physicians Committee Report.*

(13) MATERNAL MORTALITY COMMITTEE REPORT

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends *the Report of the Maternal Mortality Committee be adopted.*

(14) RESOLUTION 3—Use of Physical Therapy Equipment by Unqualified Personnel

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends *adoption of a substitute resolution in lieu of Resolution 3, as follows:*

Resolved, That the OSMA encourage all physicians to assist in the proper usage, by authorized personnel, of all physical therapy equipment in their areas of the state; and be it further

Resolved, That the OSMA House of Delegates recommend to the Council on State Legislation that the state law be strengthened that regulates the sale of physical therapy equipment and should include appropriate qualifications for those health professionals who operate such equipment.

(15) RESOLUTION 7—DRGs

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 7 be adopted and forwarded to the AMA House of Delegates.*

(16) RESOLUTION 8—Key Man

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends *adoption of Resolution 8 and that it be forwarded to the AMA House of Delegates with a change in the term "Key Man" to "Key Physician."*

(17) RESOLUTION 13—Stronger Penalties for Practicing Medicine Without a License

RECOMMENDATION:

Mr Speaker, your Reference Committee recommends that *Resolution 13 be adopted.*

(18) RESOLUTION 16 — "Baby Doe" Rule — Mandating Care for Handicapped Infants

RECOMMENDATION:

Mr Speaker, your Reference Committee heard considerable testimony on this resolution, and recommends that *Resolution 16 be adopted.*

Mr Speaker, this concludes the Report of Reference Committee III. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,
Thomas C. Alexander, MD, Chairman
Chester L. Bynum, MD
John D. Hastings, MD
S. Fulton Tompkins, MD
Carl H. Guild, MD
James V. Miller, MD
Lyle Kelsey, Staff
Ann McWaters, Staff

**Report of the
COUNCIL ON GOVERNMENTAL
ACTIVITIES**

SUBJECT: Annual Report

PRESENTED BY: Perry A. Lambird, MD,
Chairman

REFERRED TO: Reference Committee III

INTRODUCTION:

The often-predicted federal onslaught against the ever-rising costs of Medicare and Medicaid has occurred, and even more cuts appear in the offing. The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 was the first of a series of steps that are expected to reduce or at least contain federal expenditures for Medicare and Medicaid. TEFRA and the Social Security amendments recently passed by the Congress made significant changes in Medicare, including the controversial Diagnostic Related Group (DRG), pricing system for hospital care and physicians' services payment based on Reasonable Compensation Equivalents (RCE).

OSMA's Council on Governmental Activities and Mr John Montgomery, our Washington Representative, have maintained close contact with our congressional delegation during the debate and enactment of these laws, and we feel we have been given fair and open opportunity to present our views. Certain changes have been incorporated in final legislation which were improvements over the original language.

By virtue of their positions on the Senate Finance and the House Budget Committees, Senator David Boren and Representative Jim Jones continue to be key lawmakers in Health Policy. They (and their staff) have been especially helpful during the past two years. Representative Mickey Edwards' office, because of his relationship with the administration, has also provided major assistance.

Oklahoma's Medicare demonstration project, approved by the House of Delegates last year, is being refined and developed for submission to the proper federal authorities. The Board of Trustees approved an expenditure of "up to \$10,000" for consultants to research and write a formal presentation. We hope the report will be completed in time for a review by this House.

PSROs, an abolition target for two years,

have been given a new modified review role. They will become PROs — Professional Review Organizations, and will take on many of the characteristics of the original OURS program.

This report will review these major federal initiatives and the Council's response.

REVIEW OF ACTIVITIES:

As mentioned earlier, the association's *Medicare Demonstration Project* is being redrafted to include updated actuarial data and to identify the federal actions necessary to implement the plan. The proposal, modeled after our successful PLICO Health plan, would rearrange Medicare's deductible and co-insurance features to a front end, one-time (per year) payment and would also provide for payment of a "Stay Well Bonus" if the beneficiary did not use the policy during a one-year period. Each participant would have a trust fund from which he would pay for his medical expenditures. Objectives of the plan include: reducing overall Medicare expenditures because of more patient cost awareness; elimination of many small claims; and a reduction in utilization because of the higher front end deductible.

The plan is generally in keeping with administration philosophy. Proposals are now under consideration which will raise the deductible and co-insurance payments and allow Medicare beneficiaries to receive a voucher with which they could purchase an approved commercial health insurance policy. The Council plans to submit the plan to our congressional delegation and to administration officials in the near future.

The *Diagnostic Related Group Pricing* program (Medicare) will be implemented October 1st for hospital payments. Both OSMA and the AMA registered strong objection to the new system because there is not a sufficient body of data to indicate that it will work, or that it is superior to the existing hospital reimbursement system. The final legislation does phase in the program over a 4-year period rather than 1 year, as originally proposed.

Diagnostic Related Groupings originally was a hospital utilization review technique developed by the Yale School of Public Health. It groups hospital care by diagnosis into 467 groups for analytical purposes. The Department of Health and Human Services now will pay for Medicare beneficiaries' hospitalization on a prospective basis using a fixed dollar for each DRG group rather than the retrospective cost based system now employed. It is ex-

tremely difficult to determine the impact in hospitals since no institution-specific data are available. To further complicate the issue, Congress had directed the Secretary of HHS to study the DRG concept for physician payment for inpatient hospital care and report back for possible legislation enactment.

The Council will keep the membership apprised of developments as they occur.

Physician reimbursement on the basis of *Reasonable Compensation Equivalents* is a payment concept included in last year's TEFRA Act. It is an attempt by federal regulators to segregate costs under Part A and Part B of Medicare. All physicians who receive monies from a hospital or a nursing home (approximately 26%) will be affected by the new law. Traditionally, hospitals have assumed the administrative burden of separating Part A and Part B reimbursement on the basis of agreed upon formulas. The new law and regulations now require that services rendered for direct patient care (as defined by DHHS) must be billed to Part B. Supervisory, quality control, and other nondirect patient care services (again as defined by DHHS) are to be billed under Part A. The change will require modifications in most physician-hospital contracts, and OSMA is sponsoring an orientation session on these new regulations during this Annual Meeting. Payments under the Part A program will be based on RCEs by specialty on a fixed, hourly rate unrelated to effort, skill, or judgment.

The American Medical Association lost a major court and legislative battle over *Federal Trade Commission* jurisdiction of the learned professions. The United States Supreme Court, in a 4 to 4 deadlock, upheld a lower court ruling that permits FTC intrusion into the practice of medicine. The ruling declaring medicine subject to FTC regulations was a major setback to the AMA, who contended that medicine was state regulated and not subject to federal intervention. Legislation was sponsored in Congress supporting the AMA position and was passed in the House, only to be defeated in the Senate. With one exception, Oklahoma's national lawmakers supported the AMA-OSMA position. Current discussions among FTC, AMA, and the Congress are attempting to develop a "rule of reason" which would apply to professional regulatory activities and which would define unfair practices that would be subject to FTC authority. That definition would include "... acts or practices likely to

cause substantial injury that consumers cannot avoid, without providing offsetting benefits to consumers and competition." While a compromise has not yet been reached, it does appear possible.

The *Federal Health Planning* law has not been repealed, despite the repeated urging of AMA and most state medical societies, including OSMA. Funding has been significantly reduced, however, and the law has been amended to raise the capital improvement limit, subject to review, to \$600,000 in lieu of the existing \$100,000. The administration still seems to disfavor the law; no major efforts are apparent to fund it at previous levels, but there is not sufficient support in Congress for outright repeal at this time. The Oklahoma legislature is considering legislation that would enhance the funding of the Health Systems Agency (Oklahoma Health Planning Agency) through levies on applications for review. The bill is opposed by OSMA and the Hospital Association but does have support from the Nursing Home Association.

The Reagan Administration's long-awaited program for *Competition in the Health Care Industry* has been forwarded to Congress, and some of the proposals have already been discussed. The hospital DRG prospective pricing system, the Medicare voucher proposal, and competitive bidding are all part of the program. Although no consensus has emerged, there is serious concern over potential deficits in the Social Security health insurance trust funds. A bipartisan commission has been suggested and will probably be appointed to submit recommendations to Congress. Major changes in the programs will inevitably follow. Association representatives are in close contact with our congressional delegation on these issues.

The Association has recommended to Congress that the *PSRO* program be eliminated. The Oklahoma Utilization Review Program (OURS) has never strictly conformed to the original federal mandate. However, OURS has proved to be a useful and cost effective hospital review program that has saved Medicare and Medicaid millions of dollars. We have suggested that, in the event of federal repeal, provisions be made for a voluntary hospital peer review program that maintains a central data collection system and retrospective review like the OURS system. The new *PRO* program seems to conform to the Oklahoma recommendations. HHS has not published regulations,

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but there is support for a local, physician-dominated peer review system that would monitor hospitalized Medicare and Medicaid patients and centralize the data for review and for educational purposes. Private and self-insurers have recently contracted with OFPR for review services, which further supports the credibility of the system. If the Foundation were free of its federal mandates and restrictions, we believe that it could more adequately respond to the specific needs of Oklahoma hospitals, physicians and patients.

The Council and the Association have strenuously opposed recently published regulations that would change the *definition of "physician"* under the Medicare program. The proposed language would include optometrists, podiatrists, dentists, and chiropractors. While the Medicare law included the above named practitioners, the regulations have never been so permissive. In a letter to the Oklahoma delegation, Dr McIntyre, President of the Association, stated, "The proposed definition fails to recognize the need for entire medical supervision and responsibility for total inpatient care in the context of acute care general hospitals. Podiatrists, optometrists, and chiropractors are limited practitioners and should be deleted from this definition."

In addition to close work with our Congressional delegation on all of the legislative matters noted above, in which we have achieved many substantial changes in bills, the Council and the Association have been extremely active in the *regulatory arena*, as well. We have met with individuals in DHHS from Social Security Commissioner Svahn through numerous HCFA operating divisions. We have written formal comment on many regulations including the panoply of regulations spawned by TEFRA, the Conditions of Participation proposed rule, FDA product and device regulations, Medicaid program change notification regulations, regulations still being issued under the 1983 Budget Reconciliation Act, Medicare waiver regulations, and others. From time to time we have seen our suggestions adopted in the publication of final rules. We will continue to investigate better and more effective ways to impact upon the entire federal regulatory process.

Senator Dole has described 1983 as the year "we took care of the hospitals." He has announced that "1984 will be the doctors' turn."

We will devote our effort and resources in the battles ahead to best preserve the free and independent practice of medicine. The course will not be easy. In the end we may not win. But we shall have tried.

CONCLUSION AND RECOMMENDATIONS:

The Council proposes no major changes in its program. We request continued support for the Washington program, which costs the Association about \$24,000* per year, including the fee to our consultant and the average travel expenses incurred by him and OSMA officials traveling back and forth to Washington. We feel the Association and its members have benefited, and it is the only program of its kind in the federation. The continued endorsement of the Medicare demonstration project is essential. The expense of the Medicare consultant's expertise was appropriated from surplus funds of the Association, and no recurring expenses are anticipated.

BUDGET REQUEST: \$13,500**

Respectfully submitted,

Perry A. Lambird, MD, Chairman

Jerome M. Dilling, MD

William L. Hughes, MD

Lanny F. Trotter, MD

Orange M. Welborn, MD

Ronald H. White, MD

Charles D. Cook, MD

Richard Boatsman, MD

C. S. Lewis, Jr, MD

Ed L. Calhoon, MD

Mrs J. A. Montero

Mrs Jodie L. Edge

L. H. Charney, MD

Walter H. Whitcomb, MD

Francis D. Oakes, MD

Mr John H. Montgomery

Mrs Ellie Idstrom

*John Montgomery's contract is included in the OSMA Salary Budget (\$14,000).

**Includes \$10,000 for Medicare Demonstration Project.

TO: OSMA Council on Governmental Activities

FROM: John H. Montgomery

SUBJECT: Washington Activities

DATE: April 4, 1983

The long-anticipated crisis over health care costs and Federal revenues has dominated the discussion of Medicare revisions in Congress.

The most significant development has been a movement toward more competition rather than more Federal regulation to reduce Federal outlays. During the past month this has taken the form of Prospective Reimbursement in Hospitals. The Medicare Bill as it now stands does not alter physician reimbursement, except for a provision on suppliers to hospitals which may affect hospital-based physicians.

However, a study was ordered on the feasibility of including physician fees in DRGs. Bills introduced in the Senate would include such issues as competitive bidding for hospital-based physicians and some intrusion into setting the rates for physician services under Part B of Medicare.

Actions Taken by OSMA

There were a number of possible provisions in the Medicare Bill which would have tied fees for physician services to the DRG formula for hospitals. Most were eliminated in the preliminary discussions by the House Ways and Means Committee with Congressman Jones helping to keep these out. Our position has been for more competition through health care plans, such as the PLICO Insurance Plan, which would involve health care consumers more in making decisions on physician services.

We have met with the person in HHS who operates the demonstration programs and we have met with members of our Congressional Delegation. Their advice has been to further develop our concept with supporting statistics and analysis and that perhaps it could become a viable alternative under the pending Medicare voucher program. There is also the possibility of a demonstration with the Medicaid Program in Oklahoma.

We are fortunate that the tide has shifted away from overall government regulation. However, the move toward competition has the potential to have similar adverse effects on the present practice of medicine *if* competition is interpreted to place all cost saving measures on physicians and hospitals. The Reagan Budget proposals include such provisions as a freeze on the pay for physician services, competitive bidding on laboratory services, and other "cost cutting" provisions. We are urging the House Budget Committee to reject these. We are urging the implementation of ideas such as PLICO, but this approval is being criticized by those who still favor more government control.

We hope that the work done over the past two years on our competition proposal will bear fruit in the coming debate over Medicare reimbursement. OSMA has come out on the right side of the argument — now we have to implement it.

Report of the COUNCIL ON GOVERNMENTAL ACTIVITIES

SUBJECT: Medicare Demonstration Project
PRESENTED BY: Perry A. Lambird, Chairman
REFERRED TO: Reference Committee III

The House of Delegates approved the Council's proposed demonstration project last year. After further refinement, through discussions with federal officials and the Oklahoma Congressional Delegation, the Board of Trustees approved the hiring of a consultant to develop the plan for submission to policy-making officials. The first draft is attached (received last Friday, April 29).

While the Council has not had an opportunity to review the document, we wanted to submit it to the House for review and comment. We realize the limited time for consideration, but felt we should get some sense of direction from the House.

Respectfully submitted,
Perry A. Lambird, MD
Chairman

INDIVIDUAL HEALTH ACCOUNTS WITH A STAY-WELL BONUS PROGRAM: A MEANS FOR RESOLVING THE MEDICARE CRISIS

DRAFT

I. INTRODUCTION

This is a proposal to establish in several states or jurisdictions on an experimental basis individual health accounts with a stay-well bonus program for eligible aged Medicare recipients. Participation would be voluntary. Only those who are newly eligible for the Medicare program because they have become 65 years of age would be able to volunteer to participate in the experiment. Volunteers who participate in the experiment would:

- Receive the same benefits and services as any other non-volunteer, Medicare eligible;
- Pay the same co-payments, deductibles,

and premiums as any other non-volunteer, Medicare eligible;

- Be eligible for a cash bonus (stay-well bonus program) of \$200 if during every 12 calendar month period after their enrollment and after each anniversary of their enrollment in the experiment, they have submitted no claims for payment for the Medicare program, and;
- Be subject to *no* penalties of any kind if claims are submitted for payment.

Volunteer participants in this experiment would enjoy all the benefits of the Medicare program as well as an opportunity for an annual cash bonus of \$200 if no claims are submitted to Medicare on their behalf.

The Health Care Financing Administration (HCFA) will transfer to the participating carriers on a monthly basis 1/12 of the average annual per capita Medicare (Parts A and B) expenditure as well as the Part B premium payments for each participant in the experiment.

The carriers participating in this experiment will:

- Solicit the voluntary participation of Medicare eligibles;
- Reinsure for catastrophic coverage so that there is an upper limit of \$600 for which the carrier will be responsible after deductibles and co-insurance;
- Provide all other traditional services of a carrier operating a non-experimental program;
- Administer the stay-well bonus program;
- Establish and maintain in Federally-insured financial institutions interest-earning trust accounts in the name of each volunteer participant, and;
- Return the total amount remaining in each trust account to HCFA for re-deposit in the Medicare Trust Funds upon the death of the individual in whose name it is registered.
- Maintain all necessary data to allow a complete evaluation of this experiment.

Preliminary analysis indicates that 1,000 Medicare eligibles who enrolled in an Individual Health Account Plan with a stay-well bonus and who lived 20 years would receive all required Medicare financed health services and would have \$4.9-6.7 million returned to the Medicare Trust funds on their behalf when they died.

II. INDIVIDUAL HEALTH ACCOUNTS

The reliance of Individual Health Accounts with a stay-well bonus program as a mechanism for health care cost control is attractive because of the positive character of its incentives. Whereas co-payment and deductible oriented cost-control strategies penalize the use of services, the individual health account approach rewards economy in the use of services. There are no penalties.

Patients who have this type of health insurance coverage have a greater incentive to evaluate their use of medical services than do those of us with more traditional forms of health insurance. By assuming greater responsibility for their own use of medical services it is anticipated that the use of these services will be reduced. Such a reduction will be produced not as a result of increasing the costs of services to patients who need them but by providing an incentive for those who may not require them not to use them.

The Individual Health Account approach begins to establish a relationship between the use of health services and the premiums paid on an individual's behalf. Normally, health insurance redistributes premium payments from the healthy to the sick, creating incentives for excessive consumption of medical services.

The Individual Health Account approach has been adopted in one form or another by a variety of public and private organizations throughout this country. The Mendocino County, California, school system experience has been most publicized. The Mendocino County school system adopted an Individual Health Account health insurance program with a stay-well bonus in 1979-1980. Initial indications are that there has been a substantial reduction in claims experience among covered employees, indicating that covered individuals are carefully assessing their need for medical services in a way that they were not previously.

(Additional details on Mendocino experience)

The Oklahoma State Medical Association (OSMA) adopted an Individual Health Account health insurance program with a stay-well bonus in January, 1982, for OSMA members and their dependents, surviving spouses and dependent children of deceased members, and for physicians' full-time employees and their dependents. Results from OSMA's first year

indicate experience similar to that of Mendocino County.

(Additional details on OSMA experience)

The Quaker Oats Company has adopted within the last six months an Individual Health Account health insurance program with a stay-well bonus.

(Additional details on Quaker Oats experience)

III. MEDICARE

Medicare is a health care financing program which operates two distinctly separate components: Hospital Insurance (Part A) (HI) and Supplementary Medical Insurance (Part B) (SMI). Each component covers different services and is financed uniquely. HI pays for in-patient hospital care, skilled nursing facility care, and home health services. The HI Trust Fund is financed primarily by a portion of the payroll tax (currently employers and employees must each contribute 1.3% of earnings up to \$35,700). Additional revenue flows to the HI Trust Fund from the hospital deductible (\$304 for the first day of in-hospital care in 1983) and coinsurance for days 61-150 of a hospital stay and for days 21-100 for stays in skilled nursing facilities. SMI pays for all other Medicare services, primarily physician services. The SMI Trust Fund is financed from monthly premiums (currently \$12.20 per month but scheduled to increase to \$13.50 per month on July 1, 1983) paid by eligible enrollees, an annual deductible paid by beneficiaries (\$75 currently) and coinsurance of 20% on most covered services. Excess SMI costs over these revenue sources are made up from general revenues. In contrast, however, current law prohibits any reliance on general revenue financing of the HI Trust Fund.

IV. MEDICARE FINANCING PROBLEMS

The HI Trust Fund ended Calendar Year 1981 with a surplus of \$18.7 billion. This year end surplus is projected to decline gradually as a result of annual operating deficits which began in 1982. The HI Trust Fund will have a year-end deficit in 1987 of \$6.5 billion. Annual operating deficits are projected to increase to the \$63 to \$74 billion range by 1995. Current (CY 1983) outlays from the HI Trust Fund are only \$41.1 billion. Thus, the *annual deficit* in 1995 will be 150% greater than current year HI Trust Fund expenditures. The cumulative deficit in the HI Trust Fund will be \$300-400 billion in 1995.

Since the SMI Trust Fund has access to general revenue financing of its expenditures, its solvency is not an issue. However, the SMI Trust Fund is projected to require general revenue financing in the amount of \$31.9 billion by 1988. This is almost 2½ times the current year (1983) level of general revenue financing.

Proposals put forth to remedy these financing problems involve increases in payroll taxes, increases in beneficiary contribution to the cost of care, reductions in the type and amount of covered services and reliance on general revenue financing of the HI Trust Fund. If reliance is placed on any one of these remedies as the primary means of resolving these financing problems, the required changes would be unprecedented. The payroll tax rate would almost double by 1995 with continuing increases thereafter. Requiring each Medicare eligible to contribute sufficient funds to avoid the projected deficit would mean that *every* Medicare *eligible* would have to pay \$2,000 annually into the Trust Funds in 1995 and even more thereafter. If the HI Trust Fund deficit is to be avoided by assessing annual premiums on Medicare *users only*, they would each have to pay more than \$8,000 annually in 1995 since less than 25% of Medicare eligibles are recipients of Medicare financed services in any given year. The reductions in type and amount of services required to achieve this level of spending reduction could effectively gut the Medicare program.

If a combination of each of these approaches is relied upon, the required modifications in each individual area will be much less severe. Since each of these remedies, either singly or in combination, requires Medicare eligibles to contribute substantially more to the cost of their care, reduces program benefits or increases payroll taxes for everyone, (changes which have been resisted by politicians in the past); it is unlikely that any combination of remedies with the characteristics outlined above will achieve a high degree of political acceptability.

V. POTENTIAL CONTRIBUTION OF INDIVIDUAL HEALTH ACCOUNTS TO THE RESOLUTION OF MEDICARE FINANCING PROBLEMS

Appendix A illustrates the potential funds flow for an Individual Health Account health insurance program with stay-well bonus for Medicare eligibles enjoying varying degrees of health.

- Table A-1 shows the funds flow for an individual enjoying excellent health. This individual has maximum claims of \$600 once every four years and is eligible for the stay-well bonus in three out of four years.
- Table A-2 shows the funds flow for an individual enjoying good health. This individual has maximum claims of \$600 once every three years and is eligible for the stay-well bonus in two out of three years.
- Table A-3 shows the funds flow for an individual who does not enjoy good health but who is not sick all the time. This individual has maximum claims of \$600 every other year and is eligible for the stay-well bonus of \$200 every other year.
- Table A-4 shows the funds flow for an individual who is in poor health with maximum claims of \$600 every other year and claims of \$300 every other year. This individual never qualifies for the stay-well bonus.
- Table A-5 shows the funds flow for an individual who is in extremely poor health with maximum claims of \$600 every year.

The funds flow in each Table in Appendix A is positive. At no point does the flow turn negative. This is in marked contrast to the projected need in 1995 to require all Medicare eligibles to pay \$2,000 in order to avoid a deficit in the Trust Funds.

Depending on the assumptions one makes concerning the health experience of 1,000 volunteer participants in this experiment, the amount *returned* to the Medicare Trust funds from their Individual Health accounts after their deaths and after they have received all

necessary care would range at the end of 20 years from \$4.9 million to \$6.7 million. Table 5-1 shows the derivation of the \$4.9 million figure based on the assumption that 70% of the volunteers are from the two categories with the worst health as indicated by their claims experience. Table 5-2 shows the derivation of the \$6.7 million figure based on a bell-shaped curve distribution among the various degrees of health.

These Tables as well as those in Appendix A indicate that the Individual Health Account approach is a potentially powerful mechanism for health care cost containment. Such an approach does not require all of the politically difficult changes and shifts in program costs which have characterized such efforts in the past.

Table 5-1

Health Status	(1) % of Volunteers	(2) #	(3) Account Balance	(4) Total (2)x(3)
Excellent	10%	100	\$10,531	\$1,053,100
Good	10	100	9,135	913,500
Not Good but Not Poor	10	100	7,070	707,000
Poor	35	350	5,650	1,977,500
Extremely Poor	35	350	590	206,500
Total	100%	1,000	—	\$4,857,600

Table 5-2

Health Status	(1) % of Volunteers	(2) #	(3) Account Balance	(4) Total (2)x(3)
Excellent	15%	150	\$10,531	\$1,579,650
Good	20	200	9,135	1,827,000
Not Good but Not Poor	30	300	7,070	2,121,000
Poor	20	200	5,650	1,130,000
Extremely Poor	15	150	590	88,500
Total	100%	1,000	—	\$6,746,150

APPENDIX A

Funds Flow With Assumptions Concerning Health of Volunteer Medicare Eligibles

ASSUMPTIONS

1. All amounts are in constant dollars.
2. Amount deposited is set at \$1200—the average amount expended from the HI and

SMI Trust funds on each eligible Medicare enrollee in 1980.

3. Interest is earned only on the carryover balance and only at a rate of 5% annually.
4. All participants in the experiment, even those in the worst health (as indicated by maximum claims every year), survive until age 85.

TABLE A-1
Excellent Health

Age	65	66	67	68	69	70	71	72	73	74	75
Carryover	—	16	432	870	1,330	1,413	1,900	2,411	2,948	3,111	3,683
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	—	—	22	44	67	71	95	121	147	156	184
Claims	(600)	—	—	—	(600)	—	—	—	(600)	—	—
Rebate	—	(200)	(200)	(200)	—	(200)	(200)	(200)	—	(200)	(200)
Net	16	432	870	1,330	1,413	1,900	2,411	2,948	3,111	3,683	4,283

Age	76	77	78	79	80	81	82	83	84	85
Carryover	4,283	4,913	5,175	5,850	6,558	7,302	7,683	8,483	9,323	10,205
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	214	246	259	292	328	365	(384)	424	466	510
Claims	—	(600)	—	—	—	(600)	—	—	—	(600)
Rebate	(200)	—	(200)	(200)	(200)	—	(200)	(200)	(200)	—
Net	4,913	5,175	5,850	6,558	7,302	7,683	8,483	9,323	10,205	10,531

TABLE A-2
Good Health

Age	65	66	67	68	69	70	71	72	73	74	75
Carryover	—	16	432	870	930	1,392	1,878	1,988	2,503	3,044	3,212
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	—	—	22	44	46	70	94	99	125	152	161
Claims	(600)	—	—	(600)	—	—	(600)	—	—	(600)	—
Rebate	—	(200)	(200)	—	(200)	(200)	—	(200)	(200)	—	(200)
Net	16	432	870	930	1,392	1,878	1,988	2,503	3,044	3,212	3,589

Age	76	77	78	79	80	81	82	83	84	85
Carryover	3,589	4,184	4,409	5,045	5,713	6,015	6,732	7,485	7,875	8,685
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	179	209	220	252	286	301	337	374	394	434
Claims	—	(600)	—	—	(600)	—	—	(600)	—	(600)
Rebate	(200)	—	(200)	(200)	—	(200)	(200)	—	(200)	—
Net	4,184	4,409	5,045	5,713	6,015	6,732	7,485	7,875	8,685	9,135

TABLE A-3
Not Good but Not Poor Health

Age	65	66	67	68	69	70	71	72	73	74	75
Carryover	—	16	432	470	910	972	1,437	1,525	2,017	2,134	2,657
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	—	—	22	24	46	49	72	76	101	107	133
Claims	(600)	—	(600)	—	(600)	—	(600)	—	(600)	—	(600)
Rebate	—	(200)	—	(200)	—	(200)	—	(200)	—	(200)	—
Net	16	432	470	910	972	1,437	1,525	2,017	2,134	2,657	2,806

Age	76	77	78	79	80	81	82	83	84	85
Carryover	2,806	3,362	3,546	4,139	4,362	4,778	5,033	5,701	6,002	6,718
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	140	168	177	207	218	239	252	285	300	336
Claims	—	(600)	—	(600)	—	(600)	—	(600)	—	(600)
Rebate	(200)	—	(200)	—	(200)	—	(200)	—	(200)	—
Net	3,362	3,546	4,139	4,362	4,778	5,033	5,701	6,002	6,718	7,070

TABLE A-4
Poor Health

Age	65	66	67	68	69	70	71	72	73	74	75
Carryover	—	16	332	365	699	750	1,104	1,175	1,550	1,644	2,042
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	—	—	17	18	35	38	55	59	78	82	102
Claims	(600)	(300)	(600)	(300)	(600)	(300)	(600)	(300)	(600)	(300)	(600)
Rebate	—	—	—	—	—	—	—	—	—	—	—
Net	16	332	365	699	750	1,104	1,175	1,550	1,644	2,042	2,160

Age	76	77	78	79	80	81	82	83	84	85
Carryover	2,160	2,584	2,729	3,181	3,356	3,840	4,048	4,566	4,810	5,366
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	108	129	136	159	168	192	202	228	240	268
Claims	(300)	(600)	(300)	(600)	(300)	(600)	(300)	(600)	(600)	(600)
Rebate	—	—	—	—	—	—	—	—	—	—
Net	2,584	2,729	3,181	3,356	3,840	4,048	4,566	4,810	5,366	5,650

TABLE A-5
Extremely Poor Health

Age	65	66	67	68	69	70	71	72	73	74	75
Carryover	—	16	34	52	71	91	112	134	157	181	206
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)
Interest	—	2	2	3	4	5	6	7	8	9	10
Claims	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)
Rebate	—	—	—	—	—	—	—	—	—	—	—
Net	16	34	52	71	91	112	134	157	181	206	232
Age	76	77	78	79	80	81	82	83	84	85	
Carryover	232	260	289	319	351	385	420	457	496	537	
Deposit	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	1,200	
Administration	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	(84)	
Catastrophic	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	(500)	
Interest	12	13	14	16	18	19	21	23	25	27	
Claims	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	(600)	
Rebate	—	—	—	—	—	—	—	—	—	—	
Net	260	289	319	351	385	420	457	496	537	590	

Report of the COUNCIL ON STATE LEGISLATION

SUBJECT: Annual Report

PRESENTED BY: William L. Hughes, MD,
Chairman

REFERRED TO: Reference Committee III

INTRODUCTION:

The OSMA Council on State Legislation is instructed to monitor state legislation that may have an impact on the practice of medicine in Oklahoma. If necessary, the council may develop legislative policy for consideration by the

Board of Trustees and otherwise prepare and give testimony on specific legislative bills. When applicable, the council may get involved in the regulation process within state agencies as it relates to legislative implementation.

REVIEW OF ACTIVITIES: (May 1982-May 1983)

Legislative Interim June 1982 through December 1982

The council was represented on several legislative projects during the summer and fall interim of 1982. The details of both of these pro-

jects will be contained in separate reports as follows:

Report A, Project '89ers — Senator Roger Randle (Tulsa) organized and conducted a series of meetings to define the areas of necessary expenditures for state revenues over the next five years. The OSMA Council on State Legislation was actively involved in this project serving on the Sub-Committee on Health Services. The Sub-Committee chaired by Senators Al Terrill (Lawton) and Phil Watson (Edmond) concerned itself with projections for expenditures in health and related areas over the next five years. (See Report A)

Report B, Ad Hoc Committee on Medicare — Senator Bernest Cain (Oklahoma City) chaired this committee to discuss ways of identifying and alleviating some of the perceived problems of the Medicare recipients. (See Report B)

The Legislative Council met several times in the fall of 1982 to discuss various legislative issues that would be present during the 1983 legislative session. The council discussed potential legislation to be introduced by Representative Carl Twidwell of Midwest City requiring all physicians that treat cancer patients to file a report with the Oklahoma State Department of Health detailing the type of cancer, treatment, and results of treatment.

The Legislative Council is working with the State Department of Health in developing a pamphlet on breast cancer and modes of treatment available. This project was undertaken due to a commitment to several legislators to develop a pamphlet on a voluntary basis rather than mandate it through legislation. A draft copy of the brochure is attached to this report as Item C.

The OSMA Legislative Council has also been actively involved in the establishment of a statewide cancer information telephone line. The Council Chairman and OSMA Staff serve on the Advisory Committee to the Oklahoma Cancer Information Line and they will have an exhibit during the annual meeting for physicians to become familiar with this resource for their cancer patients and families.

The Council also studied and developed legislation to control indiscriminate establishment of multi-phasic screening clinics either mobile or stationary within the state of Oklahoma. This legislation has been introduced during the 1983 legislative session as Senate Bill 253.

The Council has also discussed the need for more involved record keeping of legislative ac-

tivities through the use of computer storage and word processing system. The Legislative Council has developed and retained its key legislative contact program on a manual index card system. Many council members indicated that converting this information to an electronic system would expedite legislative contact information, correspondence, and newsletters.

Over the past several years, Oklahoma legislators have passed legislation that would legalize the medical use of certain substances unapproved by the Food and Drug Administration. These legislative bills are most difficult to deal with as they are totally supported with personal testimony and the medical claims are supported with no research data. Council members have testified before the state legislature as to the adverse consequences for continuing this practice. The Council, in an effort to continue educating the legislators, developed a White Paper on the issue of legalizing unapproved drugs and treatment. The White Paper is written specifically to the Oklahoma legislature and should be read with that in mind. A copy of the White Paper is attached.

RESOLUTIONS PASSED BY THE 1982 HOUSE OF DELEGATES:

Resolution #7 — Voluntary repository for adverse reaction to legislated drugs and treatment.

The Council discussed the implementation of this resolution at its December 1982 meeting. The purpose of the resolution was for any OSMA member that noted an adverse reaction to any of the legislated drugs, ie, Laetril, DMSO, Lily-Verum, and Immuno-Augmentative Therapy, to contact the OSMA and register that information. The Council members felt that the information should be transmitted by telephone as opposed to a printed form. The Council will publicize the system within the OSMA membership and monitor the response to determine effective utilization.

Resolution #14 — County Medical Legislative Meetings.

This resolution was passed to encourage the county medical societies in Oklahoma to designate one of their regular meetings to invite their local state legislators for either a reception or topical discussion. A letter was sent to all of the county medical society presidents informing them of the resolution and encourag-

News / PROCEEDINGS

ing them to act accordingly. The response was very good and a random check indicated that approximately eleven counties had scheduled some type of legislative awareness meeting. Several county societies are considering a yearly meeting with their local legislators to discuss issues. The OSMA Council on Legislation encourages those counties who have not yet responded to Resolution #14 to do so in the near future.

AUXILIARY LEGISLATIVE PROJECTS:

The OSMA Council on Legislation conducted a legislative workshop on November 10, 1982, with the state auxiliary. The workshop featured William L. Hughes, MD, and Lyle Kelsey, OSMA Staff, discussing the auxiliary members' involvement in the legislative process. Part of the program was an evaluation of the elections by OMPAC Secretary-Treasurer Glo Henley.

The Council also assisted the state auxiliary in planning their annual day at the legislature on February 16, 1983. The day's activities involved a combination of formal presentations from various legislators and OSMA Legislative Council chairmen and staff as well as a luncheon with the legislators. The luncheon was an excellent time for the auxiliary members and several physicians to have very informal discussions with various legislators.

1983 LEGISLATIVE SESSION:

Since the beginning of the legislative session on January 4, 1983, the Council on State Legislation has scheduled meetings for every other Tuesday evening to review and decide positions on many legislative measures. A list of the various legislative bills and their status will be made available at the annual meeting.

The Legislative Council was instructed to introduce legislation to improve our professional liability statutes. The following four bills were introduced:

House Bill 1292 — Changes in waiver privilege

House Bill 1293 — Changes in initial prayer for damages

House Bill 1319 — Recourse for frivolous lawsuits

House Bill 1383 — Disclosure of collateral sources

At the time of this report, the legislation on collateral sources was defeated in the House

Judiciary Committee and the other three measures were passed and sent to the Senate. Please refer to the bill status information for complete listing.

MEDICARE SURVEY:

Several months ago, a survey form on Medicare was sent out to the OSMA membership. The return was excellent (40%) and the Council expresses appreciation to the membership for their compliance. The survey results are attached as Item E.

CONCLUSION:

The State Legislative Council continues to express its appreciation to OSMA members for their response to the Legislative Alerts and Newsletters. The amount of legislation being introduced to change the practice of medicine is and will be increasing. This alone indicates the crucial need for more legislative involvement by the membership of the Oklahoma State Medical Association and Auxiliary.

RECOMMENDATIONS:

1. To include a representative from the various medical specialty organizations as members of the State Legislative Council.

2. Organize a legislative workshop specifically for council members and any other interested physicians.

3. Acquire and develop necessary equipment to computerize all phases of the legislative activity.

4. Continue to invite specific legislators to the council meetings both during the legislative session and during the interim. Increase and encourage more social interactions with legislators within the state association, county medical societies, and specialty organizations.

BUDGET REQUEST: \$16,600.00

Respectfully submitted,
William L. Hughes, MD, Chairman
Robert A. Ellis, MD
Billy D. Dotter, MD
Joan K. Leavitt, MD
John B. Nettles, MD
Richard J. Boatsman, MD
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Walter H. Whitcomb, MD
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Elvin M. Amen, MD
Edgar W. Young, Jr, MD
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Mrs Ellie Idstrom
Mark R. Johnson, MD
Hugh M. Conner, Jr, MD
Joseph W. Stafford, MD
Charles McCall, MD
Joe C. Cole, MD
Mrs J. A. Montero
Jerry Vannatta, MD
Steve Acker, MD

ATTACHMENTS

WHITE PAPER
Legalizing Unapproved
Cancer Drugs and Treatment

Compiled and written by
The Legislative Council of the
Oklahoma State Medical Association
and approved by the Board of Trustees
1983

PREFACE

Cancer is a frightening disease. People are terrified when they find out they have cancer. They grope for anything that will relieve their terror. They are susceptible to the claims of any person who promises them a cure, thereby easing their anxiety. Such claims may relieve anxiety, but they do not cure cancer.

Many cancer patients can be cured or have years of normal activity available to them if treatments that are recognized and proven to be effective are utilized. The Food & Drug Administration (FDA) is the agency of the Federal Government which analyzes unproven (experimental) treatments of cancer to determine the usefulness and safety of those treatments before they are made available to the American public. One of the purposes of the FDA is to protect the American people from useless or dangerous methods of treatment that are touted to be cancer cures.

To subvert the charge of the FDA without possession of scientific data superior to what is available to that agency is irresponsible. When the Legislature of the State of Oklahoma legalizes an unproven cancer treatment, your constituency is assured that the treatment is safe and effective. To support legislation legalizing unproven cancer treatments places the responsibility on you for the lives of those who take these treatments.

I. OVERVIEW: Why people seek unproven cancer remedies

As soon as traditional medicine is perceived as being unable to offer either control or cure, both patients and family may consider unorthodox and unproven methods for curing cancer. Although medicinal science has made tremendous strides in the area of cancer treatment, the medical community is slow to use the word "cure," knowing full well that treatments and procedures that can "cure" certain responsive patients will not be a cure for all patients. The successful treatment of cancer patients, from the standpoint of extending life expectancy and improving quality of life, has increased steadily. However, as long as the magic word "cure" is not mentioned, the cancer patient can fall prey to many types of unproven cancer remedies.

Several psychological factors make cancer patients highly vulnerable to exploring alternative therapies when they become aware that their disease is not responding to treatment or that the disease

has recurred. The immediate reaction is to look for an error in the diagnosis or ask for a second opinion that will contradict the presence of disease. When those avenues are unsuccessful, the patient is overwhelmed with anxiety, frustration and depression. This feeling of hopelessness makes the patient a candidate for testimonials promising instant cure with no adverse side effects. People today want to feel more in control of their own health and decisions relating to their state of well-being. That is acceptable for the person that is basically healthy or has a controllable disease. However, the cancer patient feels he has no control over his disease process.

Well-meaning friends and relatives may exert enormous pressure on the cancer patient to seek unproven methods of cancer therapy. Often patients are told that the medical community does not want to find a cure for cancer because of the high financial gain to them by prolonging the disease process. As incredible as this may seem to the average person, the scenario may become believable to a patient who is overwhelmed by a feeling of hopelessness.

II. What about orthodox medical treatment for cancer

Tremendous strides have been made in the effectiveness of medical treatment in certain categories of cancer. Medical care for cancer patients does not always center on a new drug or improved surgery to correct the disease process. Oftentimes a combination of a change in lifestyle or nutritional intake combined with certain medications have met with success. The forms of medical treatment for cancer today are proving to be very effective in the control and maintenance of the disease. Chemotherapy, radiation therapy and surgery have been effective in the fight against cancer. Many of the complaints against these forms of treatment have been the undesirable side effects that many patients experience. As medical science improves, those undesirable side effects are being diminished and the benefits of these modes of therapy are seen to increase.

Treatment programs established by the physician can often be thrown into confusion when the patient alters that treatment plan by using an unproven substance without the doctor's knowledge. The reality is that many patients, in pursuing unproven cancer remedies, often neglect the medical treatment prescribed by their physicians. By the time the patient realizes that the unproven method is not effective and he returns to medical care, the disease has spread to the point of being uncontrollable.

Medical doctors are not insensitive to the need for a cancer cure, but feel that it is imperative that a system be followed that will insure proper testing and research which will provide the maximum effectiveness and still maintain patient safety. Physicians use a tremendous amount of educational resource information from around the country evaluating cancer therapies. One such system has been developed by the National Cancer Institute (NCI). This institute has developed a nationwide cancer treatment information data base called Protocol Data Query (PDQ). The data are now available to health professionals within many hospitals, libraries and universities, including all U.S. medical schools. The data base contains over 600 active treatment plans that are part of NCI's cancer therapy evaluation program. The PDQ data base is updated each month with new protocols (treatment plans) and changes in existing protocols as well as changes in information regarding physicians and institutions. This system makes it possible for physicians to access information instantly from across the United States.

Medical research facilities and teaching hospitals all take an active part in the improvement of existing cancer treatments and surgical procedures. Many physicians throughout the United States are involved in the testing of new cancer treatments. As soon as they are determined, these test results are shared with all other physicians.

III. Who makes the determination of "approved"?

To market a new drug nationwide, a manufacturer must have approval, through a New Drug Application (NDA), from the Food & Drug Administration (FDA). One main component of the New Drug Application is the clinical data that have been developed during pre-marketing investigation of the drug. These data must support the claims made for the drug and they must be adequate to prove safety and efficacy to the satisfaction of the government. The law sets forth many requirements that must be followed during the

investigational stage of the development of a drug prior to approval of the New Drug Application. These requirements are necessary to 1) protect the patients who take the drug, 2) determine the true usefulness of the drug, and 3) determine the safety of the drug. Also, manufacturers are required to submit to the FDA all reports of adverse effects, clinical experience, and other relevant data on drugs already on the market. The agency can require updating of labelling to keep precautionary information current. It can also take steps to have claims deleted that it considers no longer warranted, or even to suspend (*ie*, revoke) a New Drug Application and remove the drug from the market, if evidence discloses the drug not to be safe and effective as originally believed.

A cancer remedy can be given approval by fulfilling the scientific criteria required for any medical therapeutic claim and by making the materials and methods available for study by others. Confidence can only be placed in the remedy when results claimed by the original proponent have been confirmed by other scientists knowledgeable in the field. The standards of investigation in cancer include at least the following criteria: 1) complete examination of the clinical evidence offered by the proponent, 2) analysis of the material or methods used, 3) trial on experimental animals if indicated, 4) confirmation by other scientists of the original experiments by the proponent, 5) assessment of the results of the remedy used in each case: a) compared to other therapy, and b) compared to the natural course of the disease, 6) examination of autopsy data on patients who were treated with the remedy, 7) consultation with other investigating groups and research workers, and 8) publication of all experimental data, both laboratory and clinical, in generally recognized scientific publications which have wide distribution.

The U.S. Food & Drug Administration has been given the task by Congress to protect the people of the United States from dangerous or useless medicines by determining and regulating the safety and efficacy of all drugs that are used in the medical care of humans.

IV. Assessment of current situation

Over the years, the Food & Drug Administration has received a great deal of criticism of its regulation of drugs and medicine. Most of the criticism has centered around the length of time that elapses between receipt of a New Drug Application and the introduction of the drug into the market place. The FDA has a monumental task when considering the numbers of research projects underway in the United States every day of the year. The volume of test results, experiments, and reams of scientific research that is reviewed by this one agency is phenomenal. In one way, the FDA has fallen prey to being its own worst enemy by becoming mired down in the bureaucracy's red tape. However, in the light of a growing legalistic society, the need for greater public safety in the area of drugs and medicine has increased.

With specific reference to cancer, many so-called "cancer cures" claim to be nontoxic. Proponents of these treatments claim that, since the substance is virtually harmless and the cancer patient is terminal, FDA approval is counterproductive. First of all, it is incorrect to consider cancer patients terminal. Many cancers today are being cured or maintained on very traditional, acceptable, proven methods. Secondly, without proper testing and scientific research, who can say that a "harmless" cancer remedy is, in fact, harmless? How many people thought to have died of their cancer have actually expired from effects of their unproven cancer remedies?

Today, out of frustration with the system (FDA), many people ask their state legislators to pass legislation allowing certain substances to be used in the treatment of cancer — with very little more documentation than personal testimonials. Out of compassion, many state legislators have responded and passed legislation in an effort to try "to do something" in the fight against cancer. Oklahoma now has statutes that allow the use of Laetrile, Lily-Verum, and Immuno-Augmentative Therapy. The list will not stop until legislators learn how to deal with the frustration of the problem before them.

Legislators need to be aware of their moral responsibility to the public before giving a stamp of approval for a substance that has not gone through strict scientific research. Constituents assume that legislative approval would not have been given unless the treatment was safe and effective.

V. Summary

Oklahoma is being described as the new frontier for legislating the use of unproven drugs and medicines for the cure of cancer. The consequences of this can be rather disturbing when the cancer patient is confronted with so many alternatives that may, in fact, interfere with the correct diagnosis and best treatment of the patient's condition. Many patients can delay medical treatment and use unproven methods allowing the disease to progress to a stage where even traditional methods will be unsuccessful. The move by the public to have their legislator provide the method of circumventing the FDA is a very serious step backwards in good, safe and effective medical care.

To establish a law on the books in the state of Oklahoma, one must work within the legislative process to provide the issue with fair hearings and scrutiny, in order to have an effective and applicable law. Likewise, in the medical profession all proposed drugs and treatments must go through an established evaluation system.

Legislators who are approached by individuals seeking legalization of unapproved cancer remedies should consider consulting medical authorities before taking any action.

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STATUS OF SENATE BILLS

May 2, 1983

Bill #	Subject	OSMA Position	Status
15	Repeal of Mental Health Sterilization Laws	Support	Passed House
32	Appropriations for PMTC	Support	House Committee
62	Changes in emergency detention of mentally ill	Support	Passed House Committee
73	Oklahoma Natural Death Act (Living Will)	Monitor	Dead
80	Low-Level Radioactive Waste Compact	Support	Signed by Governor
81	Malpractice Locality Rule	Oppose	Passed House Committee
94	Strengthen penalty for robbery of drugs	Support	Passed House Committee
107	Child Passenger Restraints	Support	Dormant
142	Changing the Osteopathic Practice Act	Monitor	Passed House Committee
144	Hospital Committee information available to patients	Oppose	Dormant
145	Raising age to 21 for purchase of beer	Monitor	Passed House Committee
158	Health Services for Inmates	Support	Became amendment to another bill signed by Governor
160	Increase fines for DUI	Support	House Floor
166	Workers Compensation	Monitor	House Committee
211	Limited liability % of negligence	Support	Dormant
221	Abolishing Health Science Center Planning Commission	Monitor	House Committee
222	Recreating Health Planning Commission	Monitor	House Committee
236	Improving retention of corneas for Eye Bank	Support	Passed House Committee
237	Third Party Prescription Act	Monitor	Passed House Committee
253	Multi-Phasic Health Screening Law	Support	Dormant
263	Creating Emergency Medical Services Advisory Council	Monitor	House Committee
271	Child custody by Dept. of Mental Health	Monitor	Passed House Committee
281	Health Insurance cover drug & alcohol treatment	Support	Dead
284	Older Oklahoman's Act	Support	Dormant
297	Changing name of Community Mental Health Board	Monitor	Passed House Committee
SCR 4	One Statewide Medicare Reimbursement Zone	Support	Signed by Governor

STATUS OF HOUSE BILLS

May 2, 1983

Bill #	Subject	OSMA Position	Status
1005	Child Passenger Restraints	Support	Signed by Governor
1007	Prohibiting contamination of medicine	Support	Signed by Governor
1015	Adding saliva or urine tests for DUI	Support	Senate Committee
1019	Redefining minor for alcohol consumption	Monitor	Dormant
1021	Increasing Psychologists Board to seven members	Monitor	Passed Senate
1034	Penalties for DUI without license	Support	Senate Committee
1067	Appropriation—State Mental Health Department	Monitor	Senate Committee
1093	Selling of beer to under 21 years old	Monitor	Dormant
1095	Increasing cost of copies for medical records	Support	Dormant
1107	Catastrophic Health Insurance Coverage	Monitor	Senate Committee
1117	Selling of beer under 19 years old prohibited	Monitor	Passed Senate Committee
1133	Handicapped children—nutrition & medical treatment	Monitor	Senate Committee
1134	Requiring forwarding of missing person reports	Support	Passed Senate Committee
1157	Physician reporting form for all cancer patients	Oppose	House Committee
1159	Prohibiting random source animals for scientific research	Oppose	Dormant
1178	Redefining Osteopathic medicine	Monitor	Dormant
1182	Oklahoma Board of Chiropractic	Monitor	Senate Committee
1186	Immunity of civil liability for emergency care at accident	Support	Passed Senate Committee
1230	Identifying Health Maintenance Services	Monitor	Senate Committee
1239	Mentally retarded commitment by family	Monitor	Senate Committee
1256	Recreating State Board of Medical Examiners	Support	Senate Committee
1276	Defining wrongful birth	Monitor	House Floor
1278	Organ donation info on drivers license	Support	Senate Committee
1288	Nurses Aid Certification Act	Oppose	Dormant
1292	Allowing for exchange of medical records between plaintiff and defense	Support	Passed Senate Committee
1293	Restrictions on claims for damages against physicians	Support	Senate Committee
1315	Restricting dismissal of court action by plaintiff	Support	Senate Committee
1319	Authorize courts to dismiss actions as frivolous	Support	Senate Committee
1352	Increase dollar amount for certificate of need	Support	Signed by Governor
1374	Nursing Aid Training	Monitor	Dormant
1383	Disclosure of collateral sources	Support	Dormant
1394	Legalizing EDTA for coronary artery disease	Oppose	Senate Floor
1398	10% reduction cost for Medicaid	Monitor	Dormant
1401	Injured employees-workers comp.	Monitor	Dormant
1410	Allowing physicians to enter into certain types of contracts	Monitor	Dormant
HCR1007	Agent Orange	Oppose	Passed House
HJR1008	Federal Parent Locator Service	Support	Dormant
HCR1004	Agent Orange	Oppose	Dormant

Report A
COUNCIL ON STATE LEGISLATION
Senate Committee—Project '89ers

During the interim legislative session of 1982, Senator Roger Randle organized a series of subcommittee meetings to discuss areas of expenditures for state revenues over the next five years. The overall project was titled Project '89ers and included all aspects of expenditures within the state such as education, agriculture, and health. There were medical doctors and OSMA staff represented on the Subcommittee on Health and Social Services. The committee was chaired by Senator Al Terrill with the following legislative members: Senator Phil Watson, Senator Roy Boatner, and Senator Lee Cate. The subcommittee met twice a month to discuss the various issues of health and social services in Oklahoma and reported to the full committee on Project '89ers once a month. A list of those represented on the subcommittees is attached along with the Table of Contents of the final report and recommendations of Project '89ers. The full report is rather lengthy and a limited number of copies will be made available to the State Legislative Council. A copy of the full report is available to any OSMA member upon request.

Again, the Legislative Council expresses appreciation to those OSMA members that gave their time to participate in these subcommittee meetings.

Project '89er
Report to Senate Committee on
Appropriations Subcommittee on
Health and Human Services

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Appendix E—Local Public Health Services in Oklahoma by George W. Prothro, MD
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Appendix G—Physician Supply and Dis- tribution in Oklahoma by Lyle Kelsey
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Appendix I—Desired Characteristics for an Oklahoma Human Services Structure by Dan Arthrell
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PREFACE

This report is a compilation of findings and recommendations composed by a task force participating in the Senate Appropriations Committee Project '89er. This project was intended to collect experts' projections as to the needs in the areas of health and social services, in addition to other areas of government, over the course of the next five years.

In pursuing this objective, the participants met several times during the 1982 interim to discuss among themselves, interview state agency personnel, and present feedback to Senate panel members of the Subcommittee on Health and Social Services.

The findings and recommendations found herein have been provided by experts in the areas of health, mental health, and human services.

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SUMMARY

Although the findings and recommendations of the task force on health and social services were comprehensive, there were certain common issues that surfaced across the content areas of health, mental health, and human services. In addition, there were particular issues that were more poignant than others. Although elaboration is contained in the report, these have been condensed and summarized below.

1. Need for Better Planning and Coordination of Services

Upon reviewing the findings offered by three independent panels of experts, it is clear that each feels there is a need for better coordination of services across agencies that sponsor social services. These experts feel that there is overlap among agency services such as mental health care to children and adults.

2. Need for Evaluating Cost-Effectiveness of Existing Services

The panel experts have expressed the need to evaluate the cost-effectiveness of many social

programs. In many cases such programs have increased by 40 percent over the last two years with no indication as to whether they are achieving their goals. Before expanding or creating new services, the experts feel that it is necessary to determine which of the present services being offered (eg, various therapeutic programs; Eldercare) are the most cost-efficient and fiscally responsible. In that way, ineffective programs can be reduced or eliminated and effective programs maintained or expanded.

Report B
COUNCIL ON STATE LEGISLATION
Senate Ad Hoc Committee on Medicare

The Oklahoma State Senate passed Resolution 35 on March 18, 1982, which established an Ad Hoc Committee on Medicare to meet during the interim of 1982 with the following duties:

A. Study Medicare procedures and operations to determine the nature and extent of Medicare problems in Oklahoma with the objective of making recommendations which would improve Medicare services.

B. Prepare recommendations for state and federal legislation and policy revisions which relate to improved Medicare services and procedures.

C. Consider and evaluate previous research and studies done in this area including the Health Care Finance Administrations (one locality study of 1981).

D. Examine proposed changes in Medicare policy on the federal level and report on possible consequences of these changes.

The committee continued to meet twice a month through March 1, 1983, and to prepare a final report for submission to the State Senate, the Governor, and the Oklahoma Congressional Delegation. One representative from the following organizations served on the Ad Hoc Committee on Medicare: Governor's Committee on Aging; Alliance on Aging; National Association of Retired Persons; National Association of Mature People; Medical Rehabilitation Center of Wagoner, Oklahoma; Aetna Medicare Claims Division; Oklahoma Medical Association; Oklahoma Osteopathic Association; Oklahoma Health Systems Agency; Special Unit on Aging from the Department of Human Services; and Oklahoma

Blue Cross. The four members of the Senate on the committee were: Senator Bernest Cain, Senator Mike Combs, Senator Herb Rozell, and Senator Phil Watson.

The committee meetings were attended not only by a representative of OSMA staff but several physicians as well. Mark R. Johnson, MD, and Raymond L. Cornelison, Jr, MD, attended the committee meetings on a regular basis and discussed the various aspects of medical practice, specifically as it relates to Medicare. Many of the beginning meetings turned out to be confrontations between the elderly groups (Medicare beneficiaries) and health care providers (specifically physicians). Most of the hostility centered around trying to find someone to blame for the high cost of medical care and the hassle with filling out Medicare claim forms and the low reimbursement rate. In the beginning, the meetings were often long and seemingly nonproductive with most of the participants leaving even more frustrated. Over time, it appeared that most of the committee members were at least beginning to understand the complexity of the situation and began to look for cooperative and voluntary ways to deal with the frustrations. A good deal of time was spent on discussing the ramifications of Oklahoma changing from a multiple reimbursement zone state to one zone for the whole state. In February, the inevitable had come and the committee was going to have to vote on a number of recommendations. All of the recommendations had been read several times and had undergone numerous changes, never to the satisfaction of the committee as a whole. The final recommendations are attached to this report.

One of the most interesting recommendations was that of the one reimbursement area for Oklahoma. Again, after considerable discussion on this matter, the committee voted by a very small margin, which was contested and subsequently upheld by the chairman, in favor of asking the legislature to introduce a resolution requesting the Health Care Financing Administration to change Oklahoma from a multiple to a one Medicare reimbursement zone state. Note: Senate Concurrent Resolution 4 was introduced in the legislature this session and has passed the Senate and at the time of this writing, is on general order in the House. If SCR 4 passes the legislature, it will be sent to HCFA for implementation. At the start of the Senate Committee on Medicare, representatives from HCFA indicated a willingness to

cooperate with the state legislature if in fact they passed legislation to change to a one reimbursement zone in Oklahoma. There is now growing concern that HCFA will not honor the state legislature's request. The State Legislative Council will continue to investigate this issue and report the status at the appropriate time. The council would like to express its appreciation to the OSMA members who spent time with this committee.

*PROPOSED RECOMMENDATIONS OF
THE OKLAHOMA STATE SENATE
AD HOC COMMITTEE ON MEDICARE*

- A. Physicians should be required to provide itemized bills, including diagnoses which are suitable for attachment to Medicare claims. Although consumer credit laws require itemized bills, there is evidence that some of the medical profession may not be aware of this law. Itemized bills should become a part of the ethical practice of medicine. Physicians should be discouraged from charging for completion of a Medicare claim. The Legislature should go on record advocating that, to the maximum extent possible, claims for Medicare should be filed by the physicians' office staff. Professional associations and Medicare organizations should provide procedures simplifying the process.
- B. The Legislature should go on record urging physicians to accept assignment with far greater frequency and to be more sensitive to the economic restrictions of older patients.
- C. A list of all physicians treating Medicare patients should be published annually showing the frequency with which they accept assignment. This list should be made available to such agencies as county health departments, public libraries, Social Security offices, and local newspapers. Distribution of the list should be the responsibility of the Areawide Aging Agencies. This information will be provided by the Part B Medicare carrier with assistance from the Health Care Finance Administration.
- D. The State Tax Commission and the Legislature should strongly consider and investigate the feasibility of offering tax incentives to physicians who accept assignments of Medicare claims.
- E. The Health Care Finance Administration has offered to furnish to each Medicare Pro-

vider a list of his or her twenty-five (25) most commonly Medicare-billed services and show what the reimbursement would be for those services. This would hopefully ensure that both Medicare providers and patients would be fully informed as to the Medicare reimbursement and what the actual out-of-pocket cost to the patient would be for these services.

- F. Electronic claims filing for Medicare providers should be implemented as soon as possible. (Responses from other states have shown that this decreases the turnaround time, increases accuracy of claim filing, and reduces the amount of paperwork by the Medicare provider). Wherever possible, Aetna and Blue Cross/Blue Shield of Oklahoma should be encouraged to forward the unpaid portion of the claim to the secondary carrier. State medical journals should be encouraged to publicize the availability and value of electronic billing.
- G. A dialogue should be initiated between the Medicare providers, consumers, employers, carriers, legislators, and state and federal officials to explore the creative use of any federal demonstration projects or waivers which might improve services to Medicare beneficiaries.
- H. The Oklahoma Congressional delegation should be encouraged to seek altering of federal law to update the Medicare Economic Index used for Part B reimbursement, as it is currently substantially outdated.
- I. We recommend Congressional consideration should be given to eliminating the use of Medicare profiles. Exploration should be made of alternatives to this system. The committee noted that there are significant and sometimes startling differences in Medicare payments for certain procedures or services in different states and geographic areas.
- J. The committee noted that payments to physicians for hospital visits are significantly higher than payments for office visits, thereby providing an incentive for more costly institutional care. Wherever possible, payments for in-hospital and office care should be comparable with the specific objective of encouraging outpatient rather than institutional care.
- K. We recommend to Congress and the Secretary of the Department of Health and Human Services that regional or national

rates be set for classified groupings of physician services and procedures, with allowances for added input of physician time and for intensity of services which might be introduced by patient complications. Those rates should be reviewed and adjusted annually by an indexing method based upon the inflation rate.

- L. We recommend that funding be increased to the Medicare Part B carrier and intermediary to permit a higher level of public relations and outreach activities with providers and beneficiaries; for example, workshops, volunteer training, and so on.
- M. The committee encourages more active efforts on the part of the medical and osteopathic communities to communicate with patients through the use of brochures such as the one developed by the Tulsa County Medical Society.
- N. The committee encourages the education of older patients to communicate more effectively with their doctors. For example: medication interactions, side effects, stress factors, questions about whether a physician will accept assignment. Have the patient ask the physician about appropriate use of generic drugs, talk with doctors about any functional problems related to your medical care, suggestions for reducing your medical costs. Encourage physicians to file the claim even if they do not accept assignment.
- O. The committee noted that there have been incidents in which certain inappropriate payment demands have been made on Medicare beneficiaries. Patients should be encouraged to report problem situations to the appropriate local and state professional associations and/or medical carriers for the provider involved.
- P. The committee recommends that Oklahoma be converted from the existing five reimbursement localities to that of a single statewide locality based upon the most recent statewide prevailing rates available.

ATTACHMENT C
6th Draft—Treatment Options
For Breast Cancer Brochure

A woman's chances of surviving breast cancer are better than ever today due to early

detection through monthly breast self-examination and regular check-ups by a physician.

If a woman discovers a lump in her breast, she should not be unduly alarmed. Eight out of ten breast lumps are non malignant, but all require prompt medical attention and diagnosis.

HOW WILL THE PHYSICIAN DIAGNOSE THE LUMP?

A number of methods may be used to determine if the breast lump is malignant.

Manual palpation is performed in much the same way as breast self-examination. The physician thoroughly examines each breast in order to feel the tissue.

Aspiration is a procedure that tells the physician whether the lump is a solid mass (tumor) or a cyst filled with fluid. A needle is inserted into the lump by the physician, and fluid is withdrawn if the lump is a cyst. If it is a solid mass, the physician may be able to acquire a sample of cells to be analyzed in a laboratory.

Biopsy is the surgical removal of a small piece of tissue from the lump (or the entire lump if it is small) and a laboratory analysis of this tissue.

Mammographies are x-rays of the breast. Two methods of mammography are available; a xerography produces an image on paper and a screen film mammography produces an image on film. The National Cancer Institute recommends mammography for all women over the age of 50 and for women over the age of 40 whose mothers or sisters have had breast cancer. The Institute believes the small possible risk of radiation to the breast is outweighed by the benefits of mammography to a woman who may have undetected breast cancer. Recent improvements in mammography technology provide an accurate diagnosis while using not more than two units of ionizing radiation (rads) — making this method satisfactory to both patient and physician.

WHAT IF A SURGICAL BIOPSY IS NEEDED?

Before scheduling the biopsy, you should first discuss with your physician if the procedure will be performed as an out-patient under local anesthesia, or in a hospital with general anesthesia.

You should also use this time to decide when

to initiate treatment should cancer be diagnosed. You have two options. You can choose to begin treatment, which may require more extensive surgery, at the time of the biopsy if the tumor is malignant. This is known as the one-step procedure. Or, you can choose the two-step procedure, which allows for treatment to be performed at a later date. This gives you a chance to again consider all treatment options, obtain a second opinion, and make necessary arrangements for your treatment. The few days between biopsy and treatment *generally* will not affect the chances for a successful recovery.

Regardless of the procedure chosen, arrangements should be made to have a hormone-receptor assay performed on the tumor if it is malignant. This test measures the tumor's estrogen or progesterone dependency. Knowing whether the tumor is hormone-dependent will give your physician valuable information if further treatment is needed.

WHAT IF THE LUMP IS CANCEROUS?

A number of factors will be considered by the physician in determining breast cancer treatment. Among these are the type of cancer, size of tumor, and health characteristics of the individual.

At this point in time there is no one perfect or optimal treatment for all breast cancer patients. Each person is unique and will require a treatment procedure tailored specifically for her. The traditional radical surgery is no longer the only choice for treatment. Other, less disfiguring, surgeries are sometimes used for breast cancers detected in the early stages. As scientific research continues to provide information on the positive long-term effects of the different kinds of breast cancer treatment, the use of these alternative methods may grow. It is important that you know what options are available, so that you can play an active role in deciding which treatment is best for you.

Mastectomy is the surgical removal of the breast and has been the most common treatment for breast cancer. The type of mastectomy recommended to the patient depends on the size, location, and type of tumor. *Radical mastectomy* is the removal of the entire breast, the chest muscles underneath, and the axillary (armpit) lymph nodes. *Modified radical mastectomy* is the removal of the breast and lymph nodes in the axillary, while underlying chest muscles are left intact.

Segmental resection is the removal of a

malignant tumor from the breast along with some of the surrounding healthy tissue. This procedure has also been called *local excision*, *wide excision*, *wedge resection*, and *partial mastectomy*. Radiation therapy may be used after a segmental resection to destroy microscopic malignancies that could still be present.

The success of segmental resection and other less-than-mastectomy treatments depends on the stage of the breast cancer. Many cancer experts believe that life expectancy is increased if some type of mastectomy is performed on a breast cancer patient. However, patients' demands and the support of physicians have made alternatives available to women in an early stage of the disease.

Radiation therapy may be used when the breast lump and some or all of the underarm lymph nodes are removed. The remaining breast tissue is treated with radiation, and some cases, radiation implants are temporarily placed in the breast to supplement the external radiation.

Chemotherapy treatment is the use of drugs to destroy cancer cells. It can be used in addition to surgery or radiation to prevent or delay a recurrence of cancer. *Chemotherapy is indicated when the axillary lymph nodes are also affected by the cancer. Encouraging results have been found in researching the effectiveness of chemotherapy used in this manner.*

WHAT ABOUT BREAST RECONSTRUCTION?

Breast reconstruction is a type of plastic surgery that rebuilds the breast. Many women find adjusting to mastectomy easier if they know that breast reconstruction is possible. If you and your physician decide a mastectomy is your best treatment option, you may wish to discuss breast reconstruction and consult a surgeon who performs the procedure as you are preparing for the mastectomy.

IS A SECOND OPINION RECOMMENDED?

Asking for a second opinion does not show a lack of confidence in your physician; it is acceptable for you to seek the advice of another physician.

REMEMBER . . .

If you notice a lump in your breast, consult a physician immediately. If the physician does not know your medical history, there is certain information he/she will need to assist in a final

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diagnosis. Be prepared to give:

- Your family history of any kind of cancer
- Your age when you started to menstruate
- Date of your last period
- Your age when menopause began (if applicable)
- Your age at the birth of your first child (if applicable)
- If you have ever had a previous biopsy
- If you have had "lumpy breasts"
- If you have ever taken oral contraceptives, estrogen, or DES (diethyl-stilbesterol)
- If you have ever had x-ray treatments

QUESTIONS YOU MAY WANT TO ASK YOUR PHYSICIAN

- 1) Should mammography and/or a biopsy be performed in addition to manual palpation?
- 2) *If mammography is chosen, will it be performed by equipment that delivers both an accurate diagnosis and a low (less than 1 rad per breast) dosage?*
- 3) If a biopsy is needed, can the lump be aspirated, and will the tissue be analyzed by a cell expert?
- 4) Should the surgical biopsy be done with a local anesthetic or in the hospital under general anesthesia?
- 5) If the general anesthesia is used during the biopsy, *can* treatment be delayed until a second opinion on diagnosis and treatment is obtained?
- 6) *If the tumor is small and located close to the surface, can it be removed under a local anesthesia?*
- 7) *Can* the hospital prepare the tumor for an estrogen-receptor assay?
- 8) What type of treatments are recommended for *this* breast cancer, and what are the alternatives to mastectomy?
- 9) What is needed to make future breast reconstruction possible?
- 10) Is radiation therapy or chemotherapy needed in addition to other treatment?

ATTACHMENT E

Oklahoma State Medical Association
Medicare Survey
February, 1983

The Medicare survey received an excellent return rate with 1,007 responses out of 3,719

total mailed, or 27 percent. The percentage is actually higher if the total number mailed is decreased by those physicians who do not normally see Medicare age patients (eg, Pediatricians).

Some of the survey question results are as follows:

Question: What percentage of your Medicare patients do you routinely accept assignment? 27% of the respondents do not routinely accept assignment. 35.5% accept assignment routinely on 10% and less of their Medicare patient load. 8% of the respondents accept assignment routinely on 90%-100% of their Medicare patients.

Question: What criterion do you use in the decision of whether or not to accept assignment?

Criterion	% of Respondents
Ability to pay	38.0%
Deceased patient	12.0%
Credit worthiness	7.6%
Friends & Professional courtesy	4.4%
Medicaid involved	3.9%
Other resources	2.2%
Medicare—Hospital only	1.5%
Patient incompetence	1.1%
Patient request	1.0%

Question: Does your office complete the Medicare claim form *for the patient*? 64% of the respondents said yes. *Of the 23%* that indicated they did not fill out the Medicare claim form for the patients, 20% said they *assisted* the patient in filling out the claim form.

Question: Do you furnish an itemized statement to the patient and require them to file their Medicare claim?

Yes—47%
No—34%
Sometimes—7%

Question: Does your office charge a fee for filling out Medicare claim form? 92.5% said No, 1.7% indicated a charge was made of \$5.00 or less only on a re-file or on more than one insurance claim form.

Question: Medicare is considering publishing a list of all physicians and the frequency with which they accept assignment. What are your comments?

<i>Comment</i>	<i>% of Response</i>
Should be opposed	26.4%
Government interference	14.6%
Good idea	10.6%
No comment	5.9%
Don't care	4.5%
Won't change anything	3.4%
Comment unprintable	2.2%
Unnecessary expense	1.7%

More information from the survey will be made available in the *OSMA Journal* and newsletter.

Report of the COUNCIL ON MEDICAL SERVICES

SUBJECT: Annual Report

PRESENTED BY: John A. Blaschke, MD,
Chairman

REFERRED TO: Reference Committee III

INTRODUCTION:

The Council has been charged with the duties of studying and making decisions and formulating activities with respect to provisions of accurate medical care, including but not limited to the design of evaluation of all types of health care delivery systems, health planning, the financing of medical services, and its impact on the quality of patient care, the social aspects of health, internal peer review mechanism, and the appraisal of all external programs which affect the cost and quality of medical care.

REVIEW OF ACTIVITIES:

A. Appropriateness Review Committee — Due to the final order of the Federal Trade Commission and the order handed down by the Supreme Court, it was the AMA's interpretation and legal advice that all state medical associations desist from accepting any peer review cases directly from third-party carriers and do no fee review whatsoever.

The OSMA Board of Trustees concurred with this recommendation and has instructed our committee to follow suit. We did make one exception, and that is in the case of a fee being extremely excessive and unconscionable.

Therefore, the main activity of the committee has been reviewing cases involving appropriateness and quality of medical care and has limited the activities considerably.

B. Health Planning — Last year we were forecasting the demise of the health planning system as we then knew it. However, the health planning agencies in Oklahoma, such as the Health Systems Agency and the State Health Coordinating Council, have continued to function on a very limited basis, due to extra funding from the federal government from other states' closing down their health planning activities.

The OSMA continues to be an integral part of the HSA and the HSCC with representation by several of our members.

C. Physician Placement — Physician placement is still a vital concern of this council. Even with the cutbacks in the budgets of the various state agencies, the placement program conducted by the Oklahoma Physician Manpower Training Commission on behalf of the OSMA is working well. Much prioritizing and reallocating of funds has been done within the PMTC, but we still feel that the vital concerns are being met. We have not lost any residency positions, nor has there been a decrease in the salaries to these physicians. We should commend the OSMA members who represent us on this very important state agency. Those individuals are C. S. Lewis, Jr, MD, Tulsa; William D. Dotter, MD, Okeene; and Francis Hollingsworth, MD, El Reno. The commission also gets considerable representation from several faculty and staff members from the University of Oklahoma College of Medicine and the Tulsa branch.

D. Additional Projects — Last year the Oklahoma State Medical Association went on record in support of a single statewide Medicare reimbursement zone. The OSMA has continued to work toward this goal, and there is a full report on this in another section of your handbook.

One of the most hard-hit agencies, due to budget constraints, is the Department of Human Services. Lloyd Rader, past director of the agency, made a direct request that the Oklahoma State Medical Association assist them in finding ways to reduce their budget. The Council on Medical Services studied this situation in some depth and came up with a proposal that the OSMA made to the Oklahoma State Department of Human Services through a letter from John A. McIntyre, MD, OSMA President. A copy of this letter is provided for you as Attachment I of this report.

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RECOMMENDATIONS:

1. The Appropriateness Review Committee will continue its activities.
2. Health planning will continue to be a priority for this council.
3. The council will continue its liaison with allied health professional organizations.
4. Continue support for the Physician Manpower Training Commission and its physician placement program.

BUDGET REQUEST:

Council meeting expenses	\$1,000.00
Other council objectives	2,000.00
TOTAL	\$3,000.00

Respectfully submitted,
John A. Blaschke, MD, Chairman
Ronald S. Barlow, MD
Donald L. Cooper, MD
Kurt Frantz, MD
Maurice C. Gephardt, MD
Roger V. Haglund, MD
Bartis M. Kent, MD
Ray V. McIntyre, MD
Jane Self, MD
Orange M. Welborn, MD
Kenneth E. Whinery, MD

ATTACHMENT I

October 14, 1982

Lloyd Rader, Director
Oklahoma State Department of
Human Services
Post Office Box 25352
Oklahoma City, OK 73125

Dear Mr. Rader:

All of us share a strong mutual commitment to achieve the most effective utilization of dollars which are available for the operation of the Medicaid program in the state of Oklahoma.

The Oklahoma State Medical Association continues to regard the maintenance and improvement of quality care as the primary objective in caring for all patients. The objective of the Medicaid program has been stated to be the provision of acute medical care for those patients in low-income groups who are eligible. As Medicaid funds are reduced, some form of

rationing must be employed in order to meet these requirements. The first priority should be medical necessity, which will require setting priorities in order of importance and degree of life threatening necessity for this care. The elimination of less vital or essential programs such as medical transportation, family planning, alternate care programs and a number of social non-medical, programs is essential. The reduction of allowed numbers of hospital days, amount of ancillary services rendered and physician payment might also be necessary, but must be consistent with continued quality of care and the medical necessity of care.

The stringent review of hospitalized Medicaid patients by the Oklahoma Foundation for Peer Review has produced definite savings for Medicaid. We strongly recommend a similar review of expenditures for long-term institutional care. This expenditure in fiscal year 1981 amounted to approximately \$345 million, or about forty-six percent of the Medicaid budget. Thirty-one percent of the Medicaid dollar went to hospital services and ten percent to physicians.

Although the Department of Human Services must make the decisions regarding the exact methods of reducing expenditures consistent with revenue, the Oklahoma State Medical Association will be happy to provide help and advice in every way possible.

Please be assured of the commitment and cooperation of the Oklahoma State Medical Association in further enhancing the Medicaid program in our state.

Sincerely,

John A. McIntyre, MD, President
Oklahoma State Medical Association

JAM/sam

Report of the COUNCIL ON MEDICAL SERVICES

Report: A

SUBJECT: Medical Orders by Non-Medical Personnel

PRESENTED BY: John A. Blaschke, MD,
Chairman

REFERRED TO: Reference Committee III

During the 1982 Annual Meeting, the House of Delegates considered Resolution 1 which

dealt with unqualified personnel in nursing homes discontinuing doctors' orders. The House adopted a substitute to this resolution in which its *Resolved* read as follows: "That the Oklahoma State Medical Association initiate a cooperative study between the Oklahoma State Nursing Home Association, the Department of Human Services, and the Oklahoma State Department of Health, to educate non-medical personnel as to the laws and regulations governing the ordering and distribution of medication in long-term care facilities in Oklahoma."

Representatives of the Council of Medical Services visited with both the Department of Human Services and the State Health Department concerning this problem. We were given copies of both the federal and the state standards and regulations governing medical orders and long-term care facilities. They are very consistent in that all medication orders that do not specifically indicate the number of doses to be administered or the length of time to be administered shall be stopped automatically after a given time period. The problem we encounter is that some institutions have been stopping orders without contacting the physician. This is due sometimes to a variety of reasons such as the physician just can't be found, or sometimes there are personality conflicts involved, etc.

We have also discussed the situation with Dr Joe Rogers, Executive Director of the Nursing Home Association, and we have been assured by all parties concerned that more effort will be given in the education of long-term care employees concerning the regulations involved with medications and that an effort will be made to work more closely with the physicians as to a procedure that will be followed in the event it is difficult to notify a physician that a stop order is going into effect.

The Council on Medical Services will continue to monitor and plans to have an update session with the Nursing Home Association representative.

Report of the COUNCIL ON MEDICAL SERVICES

Report: B

SUBJECT: Assignment of Insurance Benefits
PRESENTED BY: John A. Blaschke, MD,
Chairman

REFERRED TO: Reference Committee III

During the 1983 House of Delegates Meeting, Resolution 3, which was introduced by the

Cleveland-McClain County Medical Society and dealt with the fact that insurance companies are no longer honoring the assignment of benefits of their policies, was adopted. The *Resolved* of this resolution was as follows: "That the Cleveland-McClain County Medical Society request a statement from the State Insurance Commissioner regarding the requirement for insurance companies to honor assignment of benefits, stating his policy in those cases when the insurance company does not honor the assignment of those benefits."

We have been in contact with the State Insurance Commissioner's office and have received his assurance that when the Commission is contacted by an assignee regarding the payment of a claim, everything within their jurisdiction will be done to see that the insurance companies honor valid assignments in accordance with the state statutes.

This information has been relayed to the Cleveland-McClain County Medical Society and they have expressed their satisfaction.

Report of the OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

SUBJECT: Annual Meeting

PRESENTED BY: William M. Leebron, MD,
Chairman

REFERRED TO: Reference Committee III

INTRODUCTION:

The Oklahoma Medical Political Action Committee is a voluntary, unincorporated entity made up of individual physicians and others interested in helping political candidates get elected to office who share a similar political philosophy. OMPAC is an independent and autonomous organization managed by a Board of Directors. The Board of Directors has control over the policies and activities of the committee and serves without compensation. The OMPAC Board meets annually to conduct business of the committee and otherwise meets several times during an election year to distribute OMPAC funds to candidates.

REVIEW OF ACTIVITIES:

The OMPAC Board of Directors met three times during 1982, prior to each of the major elections, and made decisions on political contributions during the 1982 elections. The decisions were based on a combination of information obtained by the individual board members

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as well as compiled information from an OMPAC membership survey. The expenditures of OMPAC and requested AMPAC funds are as follows:

OMPAC state legislative contributions	\$24,950.00
OMPAC federal legislative contributions	\$18,450.00
AMPAC federal legislative contributions	
Direct contributions	\$3,500.00
In-kind contributions (polls & surveys)	\$6,231.00
Total OMPAC and AMPAC contributions	\$53,131.00

During 1982 OMPAC contributed to eight candidates (six seats) for Congressional races. Total amount contributed was \$18,450. Of this amount, \$16,250 or 88% went to winning candidates. OMPAC contributed to two statewide races other than House and Senate seats. Total amount contributed was \$4,450 and both candidates won their races, making this category a 100% realization of amount contributed. There were 27 Senate races this year. OMPAC contributed to candidates in 12 of these. \$4,900 was contributed to winning candidates, \$1,300 to losing candidates, and \$500 of this last amount was to a candidate who expired just before General Election. Percentage of win (79%) versus losses of 21%. There were 101 House races in 1982. OMPAC contributed a total of \$14,300 in these races and scored a magnificent win ratio. \$12,100 was spent in winning races (84.6%) as opposed to \$2,200 (15.4%) losing. OMPAC contributed a total of \$43,400 to candidates during 1982. (86.8% wins).

OMPAC membership for 1983 has shown an increase. The membership in OMPAC for the first quarter of 1983 was well over 500 members, which exceeds the membership by 150 for the same period over the last two years. Unfortunately, the membership is not very good in comparison to the potential number of physicians and auxiliary members in the state association. The OMPAC Board of Directors is still challenged with efforts to increase membership.

There will be an OMPAC exhibit at the OSMA meeting with the purpose of soliciting new memberships. Any current OMPAC member can go by the exhibit and obtain information on any of the candidates who were supported by OMPAC. On behalf of the OMPAC Board of Directors, all OSMA members are encouraged to join OMPAC, and current OMPAC members are encouraged to upgrade their membership.

Report of the AD HOC COMMITTEE ON MEDICAL MALPRACTICE

SUBJECT: Annual Report
PRESENTED BY: R. Barton Carl, MD,
Chairman
REFERRED TO: Reference Committee III

INTRODUCTION:

The Committee was charged with the responsibility of reviewing Oklahoma's Tort Statutes to determine if changes could be made that would enhance association lawyers' ability to defend professional liability cases, or would reduce the number of actions brought against physicians and hospitals. The Committee sought representation from outside the profession in hopes that a broad-based coalition might have more influence on the legislature.

ACTIVITIES:

The Committee met on two occasions. The first session was devoted to assessing the political climate in the state with regards to professional liability and to identifying potential legislation that might accomplish the Committee's objectives. In its research the Committee discovered that Oklahoma could be facing another malpractice crisis in the near future. Since the mandatory reporting of malpractice claims was initiated in 1978 the number of claims filed has more than doubled — 209 in 1978, and 454 in 1982; and the number of claims resulting in legal action has more than tripled, from 83 in 1978 to 273 in 1982. While Oklahoma's physician population has increased steadily over the same period, it is not nearly as dramatic as the increase in claims.

At its second meeting the Committee selected 4 bills for introduction in the legislature:

Modification of the Ad Damnum Clause — HB 1293 — This bill is designed to take some of the media sensationalism out of medical malpractice cases. When the plaintiff files his suit he can make only a general assertion as to the damages he seeks. Specific dollar prayers are restricted until later in the proceedings. This would hopefully preclude the million dollar lawsuit on page 1 of the newspaper and the dismissal or low award on page 27.

Access to Medical Records — HB 1292 — This bill would permit both defendant and plaintiff access to all medical records at the time the patient's medical condition is placed in issue. This would hopefully make cases easier and quicker to resolve without much of the legal maneuvering that now goes on.

Dismissal of Frivolous Suits — HB 1319 — This bill would permit the judge to determine if a suit is frivolous or without merit and would permit the judge to dismiss the case and award damages to the prevailing party. This would reduce the number of non-meritorious suits.

Collateral Sources — HB 1383 — This bill would permit the introduction in evidence of certain insurances and other income sources available to the plaintiff that offset some of the damage or expense he has incurred as the result of his injury. Hopefully this would reduce awards.

These bills were introduced, and some have passed the House of Representatives (see Council on State Legislation Report).

CONCLUSION AND RECOMMENDATIONS:

The Committee has completed its task and begs to be dissolved. We would suggest that periodically a similar committee be appointed to make a review of the statutes and other factors that influence professional liability insurance premiums.

Respectfully submitted,
R. Barton Carl, MD
Chairman

Report of the GRIEVANCE COMMITTEE

SUBJECT: Annual Report
PRESENTED BY: Orange M. Welborn, MD,
Chairman
REFERRED TO: Reference Committee III

INTRODUCTION:

The Grievance Committee is a standing OSMA committee organized for the purpose of resolving complaints against physicians brought by other physicians, patients, committees of the association or public agencies, institutions, or organizations that have cause to request the medical association's involvement in adjudicating complaints.

The committee has the responsibility of handling each case in the most appropriate and judicious way. The committee may use the various county medical societies as a means of adjudicating cases within the local community. If for any reason the local medical society does not take jurisdiction over the case in question, the state grievance committee shall thoroughly investigate the complaint and make a decision as to the resolution of the matter and, if necessary, refer the matter to the association's Board of Trustees. In the event referral to the Board of Trustees is made, the Grievance Committee shall act as presenter of the fact.

REVIEW OF ACTIVITIES:

During the past year, OSMA has received thirty-two (32) phone calls of a grievance nature and twelve (12) pieces of written communication, not necessarily generated by the telephone calls. These cases have been referred to the appropriate county medical society for resolution.

OBJECTIVE:

The objective of the committee is to mediate complaints against physicians. The committee strives to resolve the complaint to the mutual satisfaction of the complainant and the physician, thereby enhancing the association's public and intraprofessional relations. The committee works with the State Board of Medical Examiners and other professional boards and agencies to accomplish this objective.

RECOMMENDATIONS:

The method of referral to the involved county medical society be continued and the state

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grievance committee be utilized in those cases where the referral is rejected or not satisfactorily adjudicated.

Respectfully submitted,
Orange M. Welborn, MD, Chairman
Elvin M. Amen, MD
John A. Blaschke, MD
William M. Leebron, MD
C. S. Lewis, Jr, MD
Marvin K. Margo, MD
Floyd F. Miller, MD
James B. Pitts, Jr, MD

Report of the PHYSICIANS COMMITTEE

SUBJECT: Annual Report
PRESENTED BY: Joseph B. Ruffin, MD,
Chairman
REFERRED TO: Reference Committee III

INTRODUCTION:

The Physicians Committee is comprised of at least six members appointed by the President of the Oklahoma State Medical Association and approved by the Board of Trustees. The committee is commissioned to make itself available to counsel with physician-members who are having personal, professional, mental, or physical problems of a significant nature. The counseling is not to be considered disciplinary and is to be kept unofficial with regard to written records and minutes. Physician-members of the association may request such counseling or the committee may act on a referral and confront the physician-member about the availability of such counseling. The committee works with the various component societies as well as the various hospital medical staffs in lending assistance to any OSMA member who may be in need of the committee's services.

REVIEW OF ACTIVITIES:

The OSMA President and Physicians Committee Chairman met twice during the year to discuss ways of increasing the committee's visibility and acceptance within the OSMA membership. Ideas were discussed about having a toll-free number as well as workshops and seminars with hospital medical staffs and county medical societies to make them aware of the OSMA program. As a major thrust, a

program on the impaired physician will be held during the OSMA annual meeting on Saturday morning.

The committee is developing a system to deal with the impaired physician on a community basis. Specific physicians are being designated in each quadrant of the state to deal with referrals from the committee to their area. This approach has worked very well in several incidents and the committee is trying to perfect the system.

BUDGET REQUEST: \$600.00

Respectfully submitted,
Joseph B. Ruffin, MD, Chairman
William M. Leebron, MD
George A. Martin, MD
Joe L. Spann, MD
Thornton Kell, MD
James R. Rhymer, MD
Frederick A. Kuhn, MD
Joseph L. Martin, MD
Wendell M. Long, MD
Robert F. Hay, MD
David Browning, Jr, MD
Robert C. Hoffman, MD

Report of the MATERNAL MORTALITY COMMITTEE

SUBJECT: Annual Report
PRESENTED BY: Adolph N. Vammen, MD,
Chairman
REFERRED TO: Reference Committee III

The Maternal Mortality Committee has reviewed twenty-one (21) maternal deaths during the past year. This number does not represent a sudden increase in the number of deaths, but rather the identification of additional maternal deaths as the result of an intensive search for cases as far back as 1971.

Our review has emphasized the need for obtaining more postmortem examinations. This is especially important in cases in which historical information is lacking, the death is sudden, and the cause of death is uncertain or unknown.

Obstetrical delivery by lay midwives in Oklahoma has more than doubled since 1974. It is suspected that many lay midwife deliveries are unreported. These mothers and their offspring are being deprived of modern-day health care facilities and health professionals.

Reported Deliveries by Lay Midwives

Year	Number	Percent of All Deliveries
1974	96	0.23%
1976	112	0.26%
1978	145	0.32%
1980	256	0.49%
1981	215	0.40%

The committee has been informed that from the years 1971 through 1980, eleven maternal deaths were studied in which the women were delivered by lay midwives. Eight of the deaths were delivered by lay midwives because of religious reasons. This is a major problem that deserves more investigation.

Soon to be published is a paper entitled "Pre-eclampsia/Eclampsia; The Number One Cause of Maternal Mortality in Oklahoma" by Drs Richard Jennings, Warren Crosby, and Sara DePersio. Through professional and public education, we hope to continue the reduction of the maternal death rate in Oklahoma.

Respectfully submitted,
Adolph N. Vammen, MD, Chairman
Schales L. Atkinson, MD
Frank D. Barnett, MD
Shelba J. Bethel, MD
Dixon N. Burns, MD
Kathleen Carlson, MD
Warren M. Crosby, MD
Max Deardorff, MD
Sara R. DePersio, MD
Robert E. Dillman, MD
Guy W. Fuller, MD
William P. Gideon, MD
Richard T. Jennings, MD
Gordon K. Jimerson, MD
Gary LaBarre, MD
John B. Nettles, MD
R. G. Schlesinger, MD
Floyd Simon, MD
Clarence P. Taylor, Jr, MD
John W. Williams, MD

OKLAHOMA STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES

RESOLUTION: 1 (ADOPTED)

INTRODUCED BY: Tulsa County Medical Society
SUBJECT: Proposed Revisions to the JCAH's "Accreditation Manual for Hospitals" as

they Relate to the Revised "Organized Staff" Section

REFERRED TO: Reference Committee II

WHEREAS, The Joint Commission on Accreditation of Hospitals has under consideration revisions in its "Accreditation Manual for Hospitals," and

WHEREAS, It is proposed that the term "Organized Staff" be substituted for the term "Medical Staff" in the revised Standard I of the Medical Staff section, and

WHEREAS, This is a significant change in definition which creates serious deficiencies in the standard, which substantially weakens the present guidelines, and which could ultimately remove the valuable safeguards which assure the high quality of care to the hospitalized patient; now, therefore, be it

Resolved, That Oklahoma State Medical Association favor policy whereby the JCAH proposal would retain the name of the hospital staff as "the Medical Staff"; and be it further

Resolved, That Oklahoma State Medical Association petition the House of Delegates of American Medical Association by resolution at its next meeting to adopt policy favoring the identification of the hospital staff as "the Medical Staff" in the revised JCAH Accreditation Manual.

RESOLUTION: 2

(SUBSTITUTE RESOLUTION ADOPTED)

INTRODUCED BY: Tulsa County Medical Society

SUBJECT: Medical Consequences of Nuclear War

REFERRED TO: Reference Committee II

WHEREAS, The threat of nuclear war is one of the primary health concerns of our time and available data reveals that there is no adequate medical response to a nuclear holocaust; now, therefore, be it

Resolved, That Oklahoma State Medical Association support the education of the physician population and the public on the medical consequences of nuclear war.

RESOLUTION: 3

(SUBSTITUTE RESOLUTION ADOPTED)

INTRODUCED BY: Jay W. Ripka, MD

SUBJECT: Use of Physical Therapy Equipment by Unqualified Personnel

REFERRED TO: Reference Committee III

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WHEREAS, Athletes of all ages are continuing to be injured and require specialized treatment; and

WHEREAS, A licensed physician is the most knowledgeable person to diagnose and treat such injuries; and

WHEREAS, There is a law governing who can purchase physical therapy equipment, but no restriction on who can utilize such equipment; and

WHEREAS, There are untrained, unlicensed, unsupervised individuals treating injured athletes with specialized equipment which delays the injured from receiving proper care and could lead to further injury; now, therefore, be it

Resolved, That the OSMA encourage all physicians to assist in the proper usage, by authorized personnel, of all physical therapy equipment in their area of the state; and be it further

Resolved, That the OSMA House of Delegates recommend to the AMA that they encourage the Food and Drug Administration to strengthen their law governing the sale of physical therapy equipment to include who can use such equipment.

RESOLUTION: 4

(*SUBSTITUTE RESOLUTION ADOPTED*)

INTRODUCED BY: Mark A. Kelley, MD
SUBJECT: Nondiscriminatory Health Care Reimbursement
REFERRED TO: Reference Committee I

WHEREAS, End of May, 1982, OSMA annual meeting, there was presented a resolution for "Nondiscriminatory Health Care Reimbursement," which led to referral to the PLICO Board of Directors for action, and

WHEREAS, The PLICO Board did develop a questionnaire regarding Outpatient Psychiatric Benefits with the provision of the benefits being extremely limited, maximum \$75 per visit with \$1,000 annual maximum per person at an 8% increase, and

WHEREAS, Large studies have shown that high option, low deductible, Mental Health coverage is stabilized at 7.5% of the total Men-

tal Health coverage, not just the outpatient coverage, and

WHEREAS, Only Inpatient Coverage forces the use of the most expensive Mental Health Care available, that is, Inpatient Psychiatric Care, and

WHEREAS, There is evidence from many studies that adequate Mental Health coverage reduces utilizations of medical services in general, and

WHEREAS, Studies consistently show that between 50% and 75% of all people seeking medical attention in general have a major mental component contributing to their complaint, and

WHEREAS, It appears that the expense of added coverage for equitable Mental Health benefits is unlikely to cause unreasonable increase in the premium; this coverage being based, like on any other insurable item, upon a group of people sharing a common risk to pay for protection in case untoward event occurs, with ample studies showing that this is the case; also regarding Mental Health insurance with no major studies showing contraindication to this general fact similar to other insurable conditions, and

WHEREAS, Even if there were considerable increase in premium, being that physicians are charitable people, it is reasonable to provide generously to our own, particularly with the problem of impaired physicians, and

WHEREAS, The study the PLICO Board conducted did have turndown of the offered benefits by the small number of respondents of this very limited coverage for high cost, and

WHEREAS, All the information in the Nondiscriminatory Health Care Reimbursement Resolution submitted to the Oklahoma State Medical Association House of Delegates with its supplement are still true and applicable; now, therefore, be it

Resolved, That the Oklahoma State Medical Association strongly support the position of Nondiscriminatory Health Care Reimbursement for all specialties of medicine, specifically Mental Health coverage; and, be it further

Resolved, That the Oklahoma State Medical Association present to PLICO recommendation that specific restrictions regarding psychiatric care be dropped and institute coverage for Mental Health within a year of adoption of the resolution with whatever associated premium increases are necessary.

RESOLUTION: 5
(NOT ADOPTED)

INTRODUCED BY: J. Wildey Morrison, MD
SUBJECT: Mandatory AMA Dues
REFERRED TO: Reference Committee I

WHEREAS, It is the duty of the House of Delegates of the OSMA to consider the desires of its members; and

WHEREAS, It is the desire of many OSMA members that membership in the American Medical Association be voluntary, and not mandatory as currently required by the OSMA bylaws; now, therefore, be it

Resolved, That the bylaws of the Association be amended as follows in order to eliminate the mandatory AMA membership requirement:

Chapter II, *Section 2.00* should be deleted, except for the section number and title, and the following wording inserted in its place:

"*Section 2.00* AMERICAN MEDICAL ASSOCIATION DUES. Members of this Association who elect to become members of the American Medical Association shall pay AMA dues and assessments as levied for their appropriate classification of membership. AMA dues and assessments should be collected and remitted by component societies in like manner as state association dues and assessments."

Chapter V, *Section 7.036* should be amended by inserting the words "involving AMA members" so that the first sentence in that section should read, "Judicial decisions of the Board of Trustees involving AMA members may be appealed to the Judicial Council of the American Medical Association in accordance with that organization's Constitution and Bylaws."; and, be it further

Resolved, In the event the House of Delegates chooses to make AMA membership voluntary, the House should recommend that all county medical societies be instructed to amend their Bylaws accordingly.

RESOLUTION: 6
(ADOPTED AS AMENDED)

INTRODUCED BY: Council on Planning and Development
SUBJECT: Indigent Patient Care
REFERRED TO: Reference Committee II

WHEREAS, It has long been a tradition of the Medical Profession to care for patients who

need medical attention and to treat them without respect for their ability to pay for such medical care; and

WHEREAS, Economic conditions and unemployment have created a situation whereby many persons have lost their health insurance benefits or, because of loss of income, have limited resources to meet the cost of needed medical care; and

WHEREAS, Across the country state medical associations, county medical societies, business-health coalitions and others have developed plans to make certain that those in need of medical care have access; and

WHEREAS, The Oklahoma State Medical Association and its members have always responded to patients in need; now, therefore, be it

Resolved, That the Oklahoma State Medical Association and its members pledge to all Oklahomans and our patients to continue to treat all our patients with compassion and dedication in accordance with their medical needs and shall not withhold service based on inability to pay for such services, and shall uphold the tradition of providing medical care in accordance with the best interest of the patient and not his ability to pay for such professional services; and, be it further

Resolved, That the content and intent of this resolution be made public through proper channels at the appropriate time.

RESOLUTION: 7
(ADOPTED)

INTRODUCED BY: Council on Planning and Development
SUBJECT: DRGs
REFERRED TO: Reference Committee III

WHEREAS, Government participation in payment for services rendered to Medicaid, Medicare, Indian Health Services, Veterans Administration recipients, Champus, Title V, etc, has been based on an improper and inadequate premium which does not pay the full cost of rendering such care; and

WHEREAS, The present system places an unfair burden on the hospitals and the privately insured or private patient, thus escalating their proportionate cost of hospital and medical care; and

WHEREAS, Hospitals now are in a dilemma

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due to the inadequate funding by governmental programs that they now seek *any* solution for possible relief, and many have endorsed an equally unwise and untried program of prospective payment based on Diagnostic Related Groupings (DRGs); and

WHEREAS, The present administration is proposing another untried, arbitrary program of paying for services by an unrealistic program of DRG which abandons the concept of paying the just and fair cost of the services rendered each individual patient in each case; and

WHEREAS, The variation of the individual patient and each illness or health care need, and the variation of the cost of care in different regions of the country are not necessarily based on number of beds or size of facility; and

WHEREAS, There has been an inadequate effort to rectify these inequities in the present reimbursement system, placing chaotic stress on our hospitals and the private paying patient; now, therefore, be it

Resolved, That the DRG mechanism continue to be studied on a limited, experimental basis in limited areas only, and inequities in the present system of reimbursement be addressed so the governmental agencies pay their fair share of the cost of hospital care based on fully paying for what is justly expended in the patient's behalf.

(to be submitted to the
AMA House of Delegates)

RESOLUTION: 8 (ADOPTED AS AMENDED)

INTRODUCED BY: Council on Planning and Development
SUBJECT: Key ~~Man~~ Physician
REFERRED TO: Reference Committee III

WHEREAS, The American Medical Association has made a significant financial investment to improve its representation in Washington; and

WHEREAS, The officers and Washington staff of the AMA have demonstrated an outstanding ability to influence legislative outcomes; and

WHEREAS, Many legislative issues are resolved by a relatively small number of votes; and

WHEREAS, The most effective influence on

lawmakers is a "back home, grassroots" appeal; and

WHEREAS, Federation members should not expect AMA officers and staff to bear the full burden of our Washington effort; now, therefore, be it

Resolved, That the House of Delegates hereby urge state and county medical societies to develop with AMA assistance "key ~~man~~" physician contacts to aid the AMA staff in its Washington program; and, be it further

Resolved, That the House of Delegates hereby commend the AMA officers and staff (particularly the Washington staff) for their superlative efforts on behalf of the FTC issue.

(to be submitted to the
AMA House of Delegates)

RESOLUTION: 10 (SUBSTITUTE RESOLUTION ADOPTED)

INTRODUCED BY: Council on Planning and Development
SUBJECT: OSMa and Multiple Proposals to Restructure Medical Care Delivery System into Competing Economic Units
REFERRED TO: Reference Committee I

WHEREAS, There is a growing consensus nationally that costs of medical care must be controlled; and

WHEREAS, A wide variety of proposals have emerged which postulate changes in the health care delivery system from that of multiple independent practitioners into organizations of physicians in competing economic units, and

WHEREAS, A plethora of competing units is emerging in the state of Oklahoma including PPOs (Preferred Provider Organizations), HMOs, IPAs, and similar agencies who will contract with selected providers at discount rates; and

WHEREAS, The rapidly improving physician-patient ratio in Oklahoma increases the chances of success in recruitment for these types of provider organizations in Oklahoma; and

WHEREAS, Physicians of Oklahoma will probably address many questions to the OSMa regarding legality, ethicality, and propriety, and probably even seek advice on the wisdom of establishing contractual relations with Preferred Provider Organizations; now, therefore, be it

Resolved, That the OSMA establish an Ad Hoc Committee under the Council on Medical Services to begin immediately to study, recommend, and develop an action plan to include advice to its physician members in the following areas;

- a) Legal questions for Oklahoma physicians to engage in contractual agreements with provider organizations;
- b) Ethical aspects of contracting one's professional services to a provider group and at the same time provide professional services to non-group individuals;
- c) Relationships among competing provider economic groups, eg, competing hospital based groups or entrepreneur groups or church related groups, keeping in mind that extensive discounting of fees for services will be rampant;
- d) Should the OSMA establish a brokerage information service for its members to provide information analysis, negotiating assistance, and other services to physicians considering contracts for their services;
- e) And finally, consider proposals to the effect that the OSMA itself, or through PLICO or Oklahoma Foundation for Peer Review, develop its own prepayment group — PPO, HMO, IPA or similar group contracting organization.

RESOLUTION: 11
(ADOPTED AS AMENDED)

INTRODUCED BY: Council on Public and Mental Health
SUBJECT: Medical Education in Nutrition
REFERRED TO: Reference Committee II

WHEREAS, Nutrition is one of the most important health factors today; and

WHEREAS, There is an increasing interest in the use of fad diets, vitamins, and health foods by the public; and

~~WHEREAS, Physicians are not systematically educated in the area of nutrition; and~~

~~WHEREAS, Most medical schools do not require courses in nutrition;~~ now, therefore, be it

Resolved, That the Annual Meeting Planning Committee for the 1984 OSMA Annual Meeting consider ~~seriously~~ allocating some ~~or all~~ of the scientific program to the subject of nutrition; and be it further

Resolved, That the OSMA encourage the institution of a course curriculum in nutrition at the University of Oklahoma Medical School.

RESOLUTION: 12
(ADOPTED AS AMENDED)

INTRODUCED BY: Sports Medicine Committee
SUBJECT: Horseback Riding Safety
REFERRED TO: Reference Committee II

WHEREAS, Oklahoma has the fourth largest horse population in the nation and horse-related sports are of such popularity; and

WHEREAS, Horseback riding accidents are one of the leading causes of injuries from recreational activities; and

WHEREAS, These accidents are a serious cause of head injuries with resultant death or permanent residual defects; now, therefore, be it

Resolved, That the Oklahoma State Medical Association recommend that educational programs be given to parents, riding instructors, show organizers, and managers outlining the risks in horseback riding and methods to minimize them; and be it further

Resolved, That the Oklahoma State Medical Association recommend that a satisfactory, protective headgear be selected for each type of riding activity and worn when riding or preparing to ride; and be it further

Resolved, That the Oklahoma State Medical Association recommend that riding schools, horse shows, and other events in which young persons participate with horses should ~~require~~ encourage that protective headgear be worn during the activities.

RESOLUTION: 13
(ADOPTED)

INTRODUCED BY: Roger M. Atwood, MD
SUBJECT: Stronger Penalties for Practicing Medicine Without a License
REFERRED TO: Reference Committee III

WHEREAS, The authorized and illegal practice of medicine by persons not duly licensed to practice medicine in the State of Oklahoma by the Oklahoma State Board of Medical Examiners can result in severe harm to patients, both by the application of incompetent medical management and by the lack of responsible care which might otherwise have been provided by licensed medical practitioners; and

WHEREAS, The detection of unlicensed practitioners of medicine may not take place for a considerable length of time; and

WHEREAS, Oklahoma Statutes now classify

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unlicensed practice of medicine as a misdemeanor, with moderate fines of \$100-\$500 and jail terms of 30-180 days; now, therefore, be it

Resolved, That Oklahoma State Medical Association petition the Oklahoma State Legislature to enact legislation which shall deter the unlicensed practice of medicine by application upon conviction of substantial fines and lengthy periods of imprisonment; and, be it further

Resolved, That such proposed legislation shall classify the unlicensed practice of medicine as a criminal felony.

RESOLUTION: 14 (ADOPTED)

INTRODUCED BY: Perinatal Task Force
SUBJECT: Perinatal Intensive Care
REFERRED TO: Reference Committee II

WHEREAS, The birth rate in Oklahoma continues to increase at approximately six percent (6%) per year and the number of infants delivered yearly has increased from 52,000 in 1980 to 58,000 in 1982; and

WHEREAS, The number of infants born yearly who require neonatal intensive care continues to increase, ie, six to seven percent (6-7%) of births are preterm, seventy-five percent (75%) of sick newborns are born to healthy adult mothers; and

WHEREAS, The survival rates of infants transferred to neonatal intensive care units have greatly improved — sick infants who weigh 2 lbs 12 oz (1,250 grams) have the same high survival of greater than ninety percent (90%) as sick newborns who weigh 6 lbs 10 oz (3,000 grams); and

WHEREAS, The average weight of patients admitted to the neonatal intensive care units across the state is 4 lbs 8 oz (2,000 grams), ie, a large percentage of infants who are near or full term require these special facilities; few very small premature babies require these services; only ten percent (10%) of infants weigh less than 2 lbs 8 oz (1,000 grams) at birth; and

WHEREAS, The average length of stay of an infant in the neonatal intensive care unit is 21 days; and

WHEREAS, Sixty percent (60%) of infants who require intensive care are born to middle income parents; and

WHEREAS, Many (50%) sick infants are born in hospitals remote from sophisticated and complex care in neonatal intensive care units; and

WHEREAS, Rapid access to neonatal intensive care is important in providing support for these infants and continuing their good prognosis; and

WHEREAS, Current methods of transportation of pregnant women and sick infants for sophisticated maternal and neonatal intensive care are inadequate; few hospitals are able to utilize the current transport system; frequently the availability of maternal and neonatal complex care is difficult to find since neonatal intensive care units are full 1/3 to 2/3 of the time; the practitioner, trying to care for the sick mother and/or sick infant spends unnecessary time trying to find the available services for the mother and her sick infant; now, therefore, be it

Resolved, That the Oklahoma State Medical Association support the development of a perinatal transport system in coordination with The Maternal and Child Health Division of the State Health Department and the Perinatal Task Force of OSMA; and, be it further

Resolved, That this system include a central dispatch number for maternal and newborn service availability to make the care of sick newborns and mothers more efficient and cost effective.

RESOLUTION: 15 (SUBSTITUTE RESOLUTION ADOPTED)

INTRODUCED BY: Cleveland-McClain
County Medical Society
SUBJECT: Outpatient Psychiatric Coverage
REFERRED TO: Reference Committee I

WHEREAS, Physicians Liability Insurance Company, a wholly-owned subsidiary of the OSMA, formed a PLICO Health Division for the purpose of offering health insurance to OSMA members; and

WHEREAS, The original policy form approved by the PLICO Board of Directors did not provide for the payment of outpatient psychiatric services; and

WHEREAS, Psychiatrists, individually and collectively, have petitioned OSMA and PLICO to modify the policy to include outpatient psychiatric services; and

WHEREAS, PLICO did run a survey of the

physician enrollees in PLICO, and said survey received a negative response; and

WHEREAS, It is the position of the Cleveland-McClain County Medical Society that the survey was prejudicial and probably not representative of the membership of OSMA who are the owners of PLICO; and

WHEREAS, The House of Delegates is the official representative Body of the OSMA membership; now, therefore, be it

Resolved, That the House of Delegates hereby instruct the Board of Directors of PLICO to modify its PLICO health policy to include coverage for outpatient psychiatric services; and be it further

Resolved, That if this resolution is passed that the coverage become effective on the anniversary of the first policy due for renewal in 1984.

(Late Resolution)

RESOLUTION: 16
(ADOPTED)

INTRODUCED BY: Oklahoma County Medical Society

SUBJECT: "Baby Doe" Rule — Mandating Care for Handicapped Infants

REFERRED TO: Reference Committee III

WHEREAS, The decision to treat severely handicapped infants is an extremely individual one, best left to parents and physicians; and

WHEREAS, Government has no productive role in this decision; and

WHEREAS, A Federal District Court has ruled the "Baby Doe" regulations "arbitrary and capricious . . . hasty and ill considered,"* now, therefore, be it

Resolved, That the Oklahoma State Medical Association go on record as supporting the position of the American Medical Association and the American Academy of Pediatrics in opposition to the so-called "Baby Doe" rule.

*US District Court Judge Gerhard A. Gesell

(Late Resolution)

RESOLUTION: 17
(SUBSTITUTE RESOLUTION ADOPTED)

INTRODUCED BY: Oklahoma County Medical Society

SUBJECT: Chelation Therapy

REFERRED TO: Reference Committee I

WHEREAS, Chelation therapy is being promoted to the public as a cure for conditions such as blindness and senility; and

WHEREAS, State associations and local societies of the Federation need thoughtful evaluations and studies of chelation therapy in order to act effectively in preventing adverse impacts on the health of our patients; now, therefore, be it

Resolved, That the Council on Scientific Affairs of the American Medical Association study the indications, efficacy, safety, and potential benefits and risks of chelation therapy and report to the House of Delegates as soon as possible.

(Late Resolution)

RESOLUTION: 18
(ADOPTED)

INTRODUCED BY: OSMA Board of Trustees

SUBJECT: Peer and Fee Review

REFERRED TO: Reference Committee II

WHEREAS, Medical associations, county medical societies, specialty societies, and other organizations of the American medical federation have historically performed peer and fee review; and

WHEREAS, Peer scrutiny has been of immeasurable value to patients, non-patient payors of medical care, and to physicians; and

WHEREAS, Recent actions of the Federal Trade Commission and the US Department of Justice appear to severely restrict the ability of physician groups to monitor and review the medical practice, charging patterns, and payment provisions of physicians and insurers of medical services; and

WHEREAS, These actions have fostered advertising, fee abuses, and reimbursement restrictions that appear to be false, misleading, deceptive, and generally detrimental to patients and physicians; now, therefore, be it

Resolved, That the Oklahoma State Medical Association announce to the general public, the insurance industry, hospitals, physicians, and other interested parties that it will forthwith reconvene its peer review and fee review procedures; and, be it further

Resolved, That simultaneous with the above announcement the association will notify the Federal Trade Commission and the proper division of the US Department of Justice of its

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intent to reconvene these activities and, absent written rejection of the written proposal, the association will assume it conforms to federal law and regulation.

COMMEMORATIVE RESOLUTION

LOUISE MARTIN

Introduced by the OSMA Editorial Board
and the OSMA Board of Trustees

WHEREAS, Louise Martin has served as Editorial Assistant for *The Journal of the Oklahoma State Medical Association* for 26 years; and

WHEREAS, Mrs Martin throughout her years as an OSMA employee served with loyalty, dedication, and the highest degree of professionalism; and

WHEREAS, Through the years *The Journal* has received numerous national awards for excellence, largely due to the efforts of Mrs Martin; and

WHEREAS, The Medical Association, its members, its staff, and all who have had an opportunity to work with Louise over the past 26 years have benefited from her dedication, her friendship, and her love; now, therefore, be it

Resolved, That the House of Delegates hereby recognize Mrs Louise Martin for her many contributions to the medical profession, especially her kindness, gentleness, and exemplary service, and wish her Godspeed and happiness in her retirement.

COMMEMORATIVE RESOLUTION

JAMES A. MERRILL, MD

Introduced by the Oklahoma City
Obstetrical and Gynecological Society

WHEREAS, James A. Merrill, MD, served as

Head of the University of Oklahoma Medical School's Department of Gynecology and Obstetrics for 21 years; and

WHEREAS, During his tenure Dr Merrill developed an outstanding department nationally recognized for superlative programs; and

WHEREAS, Dr Merrill was the first full-time Head of the Department of Gyn-OB; and

WHEREAS, Dr Merrill had resigned his position effective July 1, 1982; now, therefore, be it

Resolved, The OSMA House of Delegates duly assembled does hereby command and express its sincere appreciation to Dr James A. Merrill for his outstanding service and many contributions to doctors and patients in Oklahoma.

COMMEMORATIVE RESOLUTION

ARMOND H. START, MD

Introduced by the Board of Trustees
of the Oklahoma State Medical Association

WHEREAS, Armond H. Start, MD, has served in an exemplary manner on many state, county, community and medical boards, commissions and committees; and

WHEREAS, Dr Start, regardless of the circumstances, has always been an outspoken proponent of medical ethics, quality medical care, and equality and justice in every endeavor in which he has participated; and

WHEREAS, As Medical Director of the Oklahoma State Department of Corrections, Dr Start has brought national prominence to the State of Oklahoma; and

WHEREAS, Dr Start has announced his resignation effective June 1 and will become Medical Director of the Texas Prison System; now, therefore, be it

Resolved, That the House of Delegates of the OSMA hereby extend its heartfelt thanks and appreciation to Dr Armond H. Start in recognition of his numerous contributions to Oklahoma medicine.

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—G. Boss, MD et al

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—Edward W. Holmes, Jr, MD

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1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION.

In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been

observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Occasional cases of hypersensitivity have been reported in patients with renal compromise receiving thiazides and Zyloprim concurrently. For this reason, in this clinical setting, such combination should be administered with caution.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age:

Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully

"The most important therapeutic measure is the administration of a drug which will block urate synthesis. The agent available at present is allopurinol (Zyloprim . . .) which is very effective and of low toxicity."³

—Alfred Jay Bollet, MD

"... allopurinol treatment appears to retard the progression of renal dysfunction."⁴

—T. Gibson, MD et al

LOW INCIDENCE OF TOXICITY

"Clinical experience with allopurinol suggests that most patients tolerate this drug well—a finding strongly supported by our data. Undesired or unintended effects of therapy were reported in only 1.8% of 1835 consecutive recipients."⁵

—G. T. McInnes, MD

1. Boss G, et al, quoted by Scott JT: Long-term management of gout and hyperuricemia. *Brit Med J* 281:1164, 1980.

2. Holmes EW Jr: A rational approach to gout. *Drug Therapy* 11:117-124, 1981.

3. Bollet AJ: Prevention and treatment of urate nephropathy and uric acid stones. *Resident & Staff Physician* 28:57-64s, 1982.

4. Gibson T, Highton J, Potter C, et al: Renal impairment and gout. *Ann Rheum Dis* 39:417-423, 1980.

5. McInnes GT, Lawson DH, Jick H: Acute adverse reactions attributed to allopurinol in hospitalised patients. *Ann Rheum Dis* 40:245-249, 1981.

observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects. Mild reticulocytosis has appeared in some patients.

Periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported. The incidence of skin rash may be increased in the presence of renal disorders.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

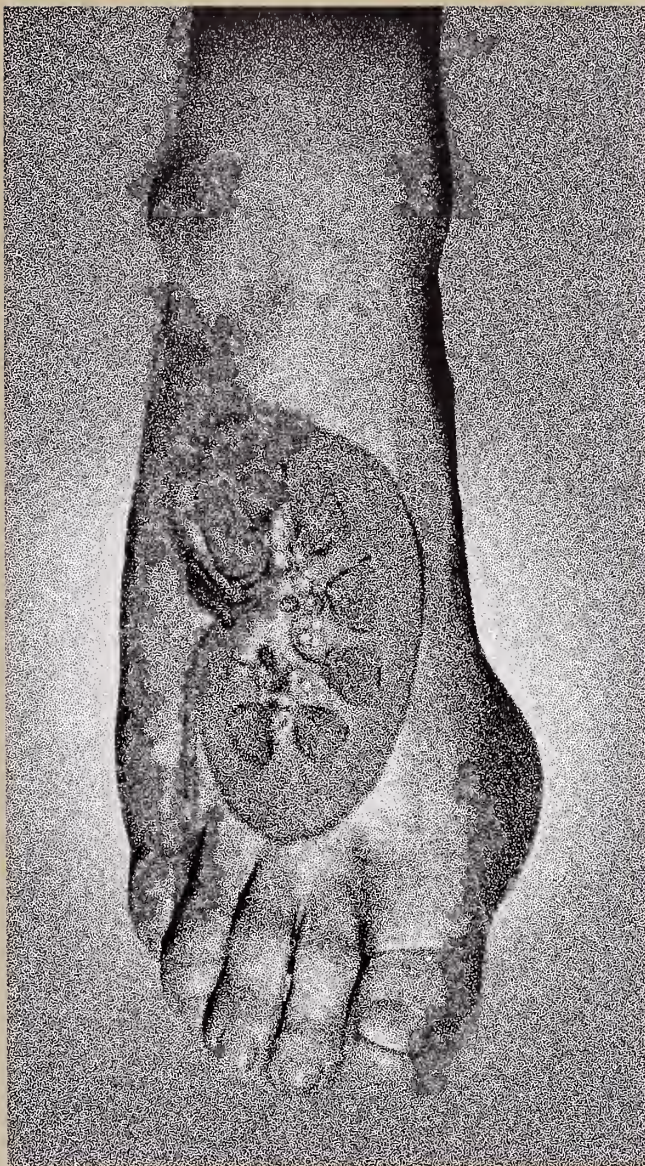
A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Hepatic: Rare cases of granulomatous hepatitis and hepatic necrosis have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.



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Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been neither implicated nor excluded as a cause of these reactions.

Renal: Rare cases of renal failure have been reported in hypertensive patients who received thiazides and Zyloprim concurrently. Some patients had evidence of hypersensitivity to allopurinol.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

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OBJECTIVE: To familiarize the primary care physician with current research and its clinical application.

ACCREDITATION: As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education, the American Diabetes Association certifies that this continuing medical education offering meets the criteria for seven and one-half (7½) hours of ACCME Category I credits provided it is used and completed as designed.

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LIST OF TOPICS

Why Control Diabetes Mellitus & Which Patients Need Control? Sherwyn L. Schwartz, M.D.
Type I Diabetes Mellitus Etiology & Approach to Control. Jay S. Skyler, M.D.
When & Why to Use a Pump or Transplant Julio V. Santiago, M.D.
When Does an Ophthalmologist See My Patient? James W. Speights, M.D.
When Should a Podiatrist See My Patient? Richard A. Pollak, D.P.M.
Type II Diabetes Mellitus (Which pill or insulin & which diet?) Jay S. Skyler, M.D.
Purified & Human Insulin - Pros & Cons. Jerome S. Fischer, M.D.
Pregnancy & Diabetes Mellitus - Gestational & Overt. Lois Jovanovic, M.D.

Also Covered: What is a Diabetes Mellitus Team & How Does It Function?
Pediatric Emergencies & Day to Day Problems.
How to Use Home Glucose Monitoring & Glycosylated Hemoglobin.
A Potpourri of Practical Problems with Diabetes Mellitus - Travel, Illness, Surgery, etc.

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For More Information Contact. Mr. Daniel Snare, Alamo Area Chapter, American Diabetes Association, P. O. Box 32635,
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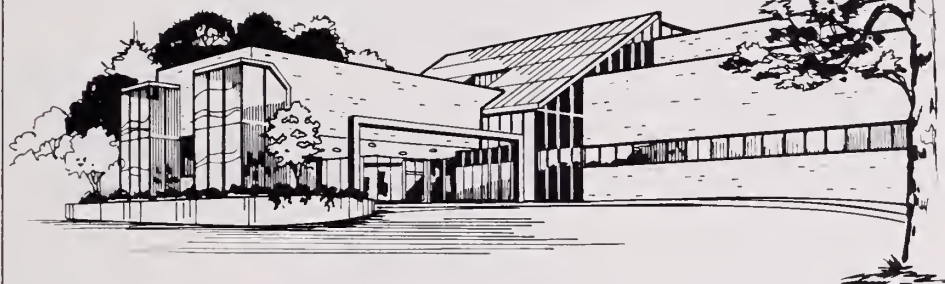
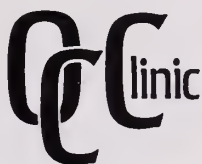
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The JOURNAL

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Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name and author, title or article, name of periodical with volume number, page and date of publication. These references should be numbered in the sequence in which they appear in the article.

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NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

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All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

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The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, P.O. Drawer 1058, Norman, Oklahoma 73070, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

Physicians are concerned over the increasing frequency of malpractice claims, especially as giant awards become more common, according to the May 31 *Wall Street Journal*. The *Journal* reports that St Paul Fire & Marine Insurance experiences an average of 4.8 claims per 100 doctors yearly, up from 2.9 in 1975. Juries made 45 awards of more than \$1 million each in 1981, up from 14 in 1979, says Jury Verdict Research, a legal publishing firm. Legislation pending in Michigan and New York would cap "pain and suffering" damages. During the 1970s, 13 states passed such limits; about half the statutes were struck down by the courts. The *Journal* says that without such legislative limits, professional liability premiums will continue to escalate.

"The Workers Comp Connection," a 30-minute color film produced by the Wausau Insurance Companies in cooperation with the American Medical Association, is available to physicians and medical societies on a free loan basis. The film focuses on the key role physicians play in holding down costs and promoting early return to work of injured employees. It also encourages closer teamwork among physicians, employers, insurers, and others to make the workers compensation system function more economically and more effectively for everyone involved. The film uses dramatizations to present situations involving physicians and includes footage taken at a meeting of a business-medicine health care coalition in Columbus, Indiana. Physicians or societies interested in obtaining a print should contact the Wausau Insurance Companies, Communications Services, 2000 Westwood Drive, Wausau, Wisconsin 54401.

The American Society of Internal Medicine has published a new guide designed to help physicians control their practice expenses and provide a range of services that best meets their patients' needs. Titled *Building and Maintaining Your Practice*, the guide offers practical and generally inexpensive steps

that can help physicians strengthen and maintain their medical practices in the increasingly competitive medical marketplace. The guide is available for \$2.00 from ASIM, 1101 Vermont Avenue NW, Suite 500, Washington, DC 20005. Bulk quantities (50 or more) are available at a discount.

Sex discrimination is alive and well among would-be parents, according to University of Miami pediatrician Shirley Press, MD. Dr Press says that "so many times in my private practice, I have seen disappointment in the faces of fathers and mothers when girls were born." She adds that parents are ecstatic when a boy follows two girls, but merely happy when a girl follows the births of two boys. Dr Press notes that no sexual preference is seen among would-be parents who have experienced hardships, such as the death of a child or fertility problems.

Soccerball-related eye injuries have nearly tripled in the past decade, according to a group of ophthalmologists from Cincinnati, New Orleans, and Concord, Massachusetts. Children aged 5 to 14 years are at greater risk of injury because of incomplete development of the bony rim around the eye socket, and they sustain almost one-third of sports-related eye injuries. The ophthalmologists recommend routine wearing of eye guards in sports involving large or small projectiles and say that soccer players, who use their heads to strike the ball, should wear cushioned eye guards.

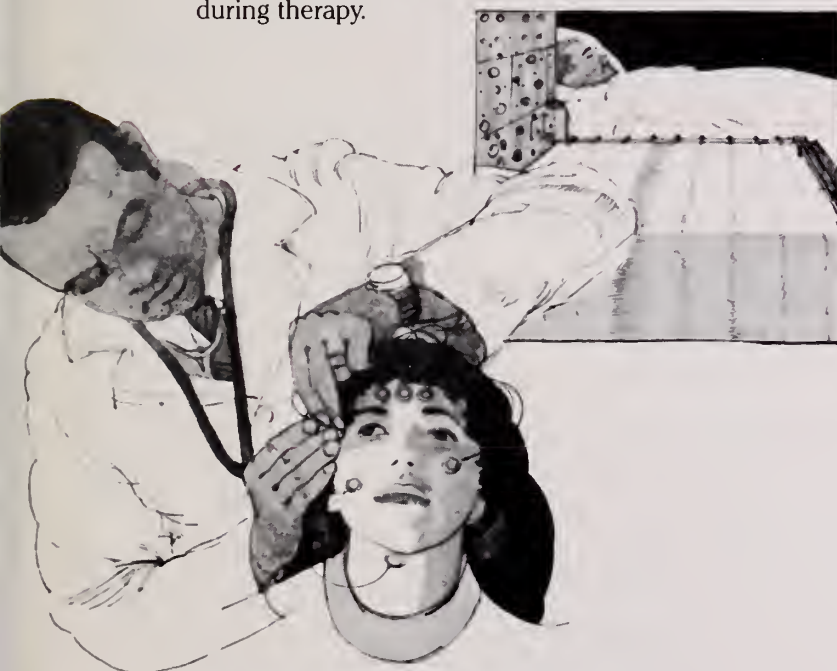
The Southern Medical Association (SMA) will hold its 77th Annual Scientific Assembly November 6-9, 1983, at the Hyatt Regency Hotel, Baltimore, Maryland. There is no fee for registration. Postgraduate course fees are \$15 for members of the SMA and \$22.50 for non-members. For meeting information contact Jeanette Stone, Southern Medical Association, 2601 Highland Avenue, PO Box 2446, Birmingham, Alabama 35201, (205) 323-4400.

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References: 1. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 4. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 5. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Kales JD: *Pharmacol Physicians* 41-6, Sep 1970. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5:25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The

sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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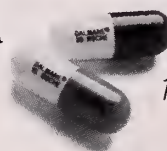
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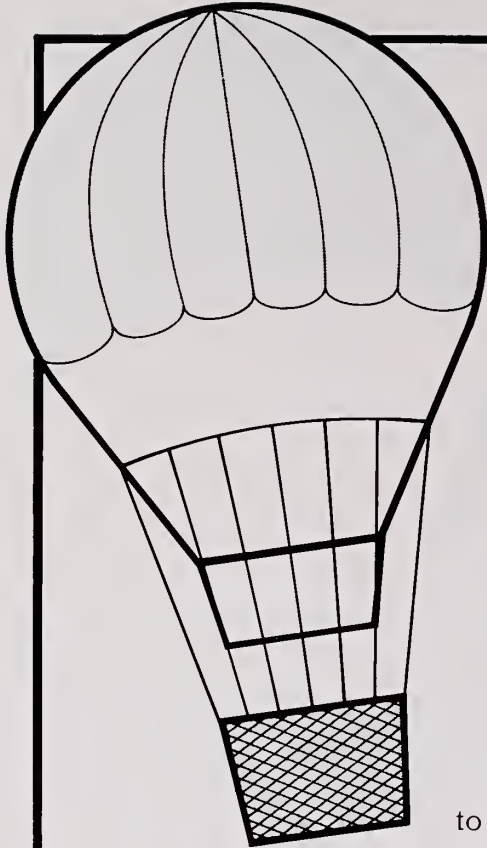
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Cooperative effort

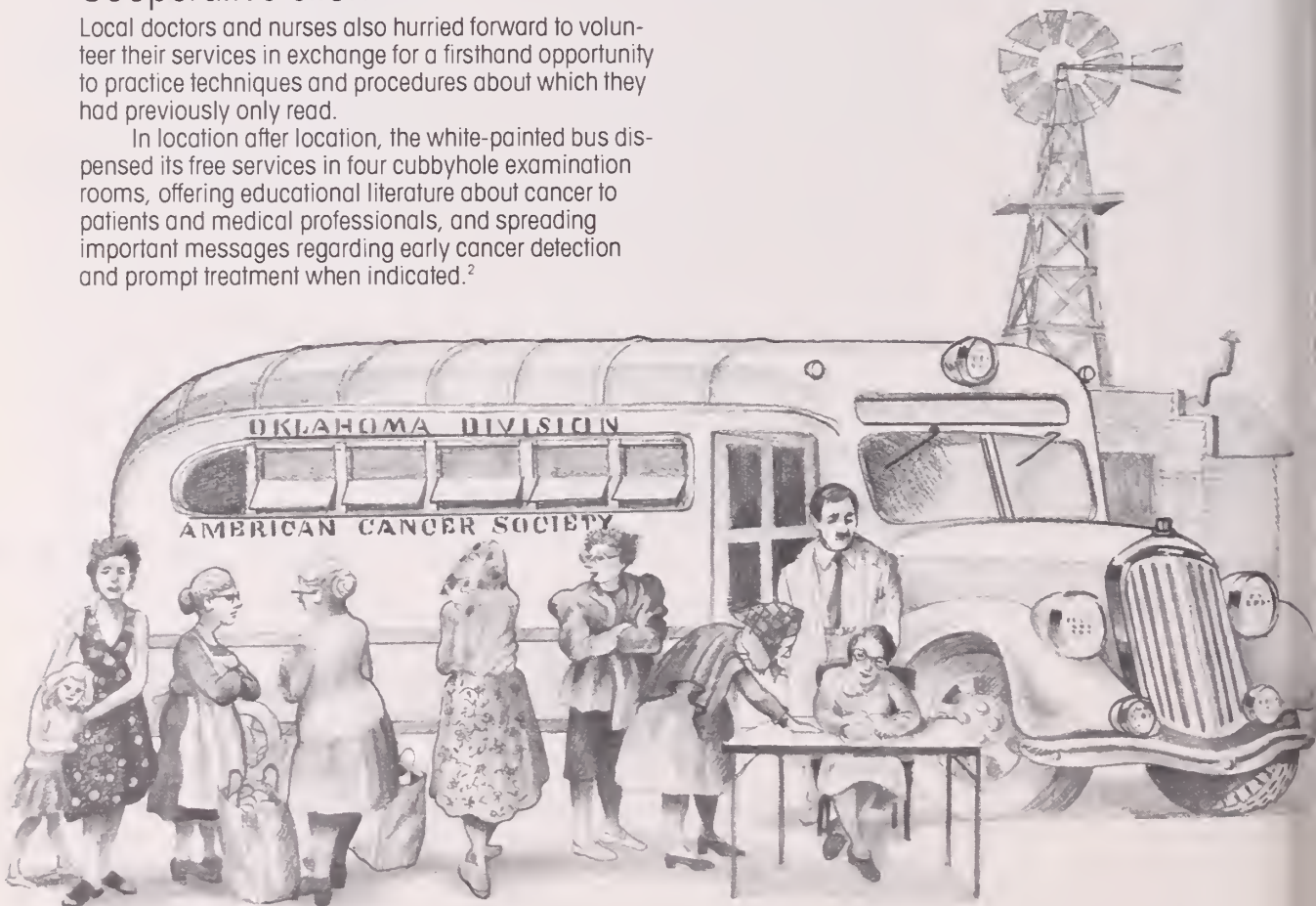
Local doctors and nurses also hurried forward to volunteer their services in exchange for a firsthand opportunity to practice techniques and procedures about which they had previously only read.

In location after location, the white-painted bus dispensed its free services in four cubbyhole examination rooms, offering educational literature about cancer to patients and medical professionals, and spreading important messages regarding early cancer detection and prompt treatment when indicated.²

The idea caught on

Today, it is not surprising to see a modern medical services vehicle on wheels in shopping-center parking areas, schoolyards or business centers. Community service organizations sponsor and support them all across the country. Unquestionably, they have come a long way in equipment and comfort from the school bus that pioneered vital health services... but *it* was the bus that made medical history.

References: 1. Kone JN: *Famous First Facts*, 3rd ed. New York, The H W Wilson Co., 1964, p. 367 2. Doto on file, Hoffmann-La Roche Inc., Nutley, NJ.



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For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

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- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K. Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jarvik ME; New York, Appleton-Century-Crofts, 1977, p. 316. 2. Feighner JP *et al*: *Psychopharmacology* 61: 217-229, Mar 1979. 3. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Please see summary of product information on following page.

LIMBITROL® TABLETS (N) Tranquilizer—Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage, withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline, symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated: sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels.

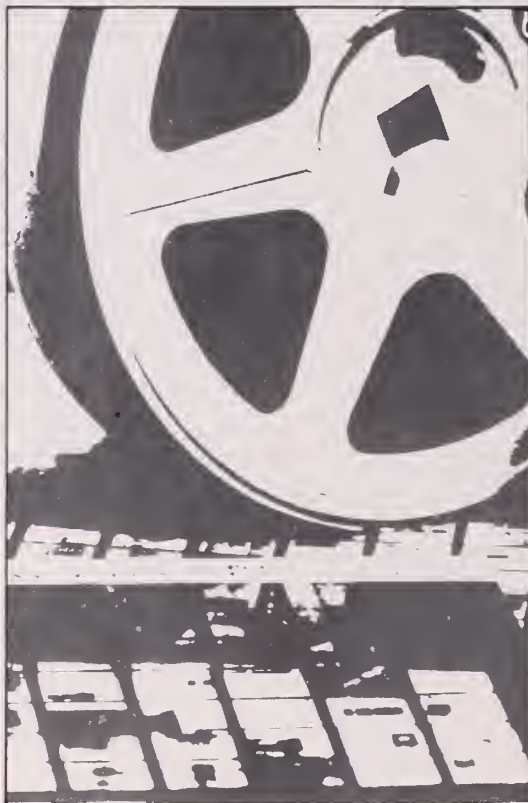
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine hydrochloride has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12.5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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JOURNAL

Oklahoma State Medical Association

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The Journal of the Oklahoma State Medical Association (USPS 285-000)

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary Consult the package literature for prescribing information

Indications and Usage: Cefaclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (Diplococcus pneumoniae), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions**—If an allergic reaction to Cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefaclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when anti-globulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clintest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefaclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefaclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefaclor® (cefaclor, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions—Adverse effects considered related to therapy with Cefaclor are uncommon and are listed below. Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

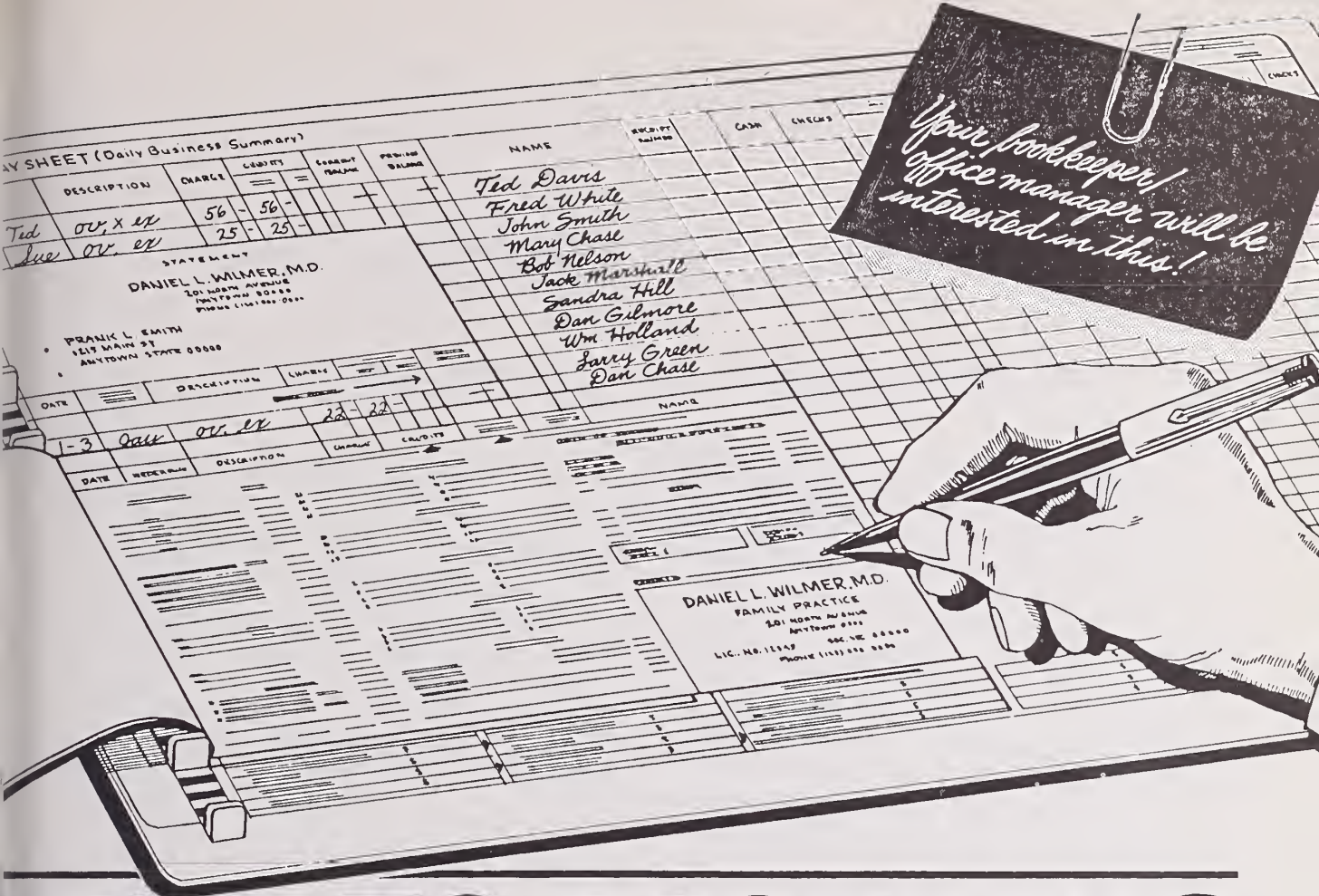
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Medicine's Mayfly: The FEC

I am somewhat fascinated and moderately amused by the current flap over the "new phenomenon in health care delivery," Free Standing Emergency Clinics (FECs), also known as storefront clinics, AM and PM clinics, and assorted other titles. Explanations for their popularity, definitions of their purpose, and justifications for their existence rain down in the storm of controversy about them generated by professional organizations, hospital-based physicians, and the ivory tower crowd. Entrepreneurs and perennial promoters — many of whom are physicians grown weary of practice or frustrated by declining incomes — are in a frenzy extolling the unique opportunities to get rich by investing in FECs.

So what are these marvelous medical merchandise marts, and what is the secret of their popularity?

Basically, the FEC is a simple, easily accessible, ground-level, old-time doctor's office containing a few items of modern medical equipment. It is open during the hours most people need and have the time to go for impromptu medical care for relatively minor problems. It differs from the old-time doctor's office in several ways but most conspicuously in not providing continuing care for chronic conditions and in not accumulating a ledger of unpaid accounts. It is a cash-and-care convenience store that cuts the heart out of the traditional physician's office practice and the hospital's emergency room patronage.

The popularity of FECs is not based on new ideas or secret formulas. They are popular because they are convenient, they provide satisfactory if not superb care, and they charge less for it — which brings us to the subject of my amusement about FECs. The reasons they can charge less for their services are painfully obvious. Most important is the fact that they are relatively unregulated. They don't have to

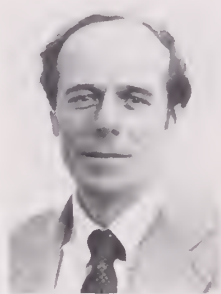
keep hours or maintain staffs established by fiat; they don't have to employ a small army of clerks and secretaries who are sufficiently cunning to extract permission to exist from the endless parade of inspectors sent by the bureaucracy. They don't have to have insurance clerks or engineers or maintain committees or type minutes or hold fire drills or establish boards of directors. They are not forced to care for the indigent or maintain laboratories or hire pathologists or radiologists or pharmacists or dieticians. They don't have millions of dollars invested in x-ray and isotope equipment and surgical machines and instruments. And they are not required to provide thousands of square feet of floor space for storage of x-rays, insurance claims, medical records, financial records, accounting records, and volumes of local, state, and federal laws, rules, and regulations.

About the only thing the FEC must do in order to be successful is provide a convenient time and place where limited but acceptable medical care is available to patients who can and do pay for it.

Two aspects of today's FEC especially amuse me. One is that most of them are managed by physicians. The other is that they soon will not be. Already there are efforts underway to license and regulate FECs. When that happens — and it will — physicians will not be permitted to manage them. The bureaucracy will — at great expense — take charge in order to protect the public. Next, the FEC will have its own accrediting agency, its own licensing board, and its own corps of inspectors. Finally, as none of them will then be generating profits, the FECs will be supported by appropriations or by contributions from the United Fund. Everyone will continue to wonder why medical care is so expensive. No one will wonder why the original FECs failed. Everyone will know why. They were managed by physicians.

— MRJ

Our association has very rarely, perhaps only twice, asked the governor of Oklahoma to veto a piece of legislation. One of these requests for a veto was successful when Governor George Nigh vetoed House Bill #1394 on May 23, 1983.



This piece of undesirable legislation would have mandated insurance payment for unproven methods of therapy such as chelation therapy, immuno-augmentative therapy, Laetrile, DMSO, and Lilium. The veto was the end result of a great deal of work by many people. All of the physicians' letters, telegrams, and calls to the governor's office were record setting in this session of the legislature, and probably record setting in the past several years' experience. The support of allied organizations in the health field, the tireless labors of our own medical association staff, and the work of our legislative committee were all essential. Support from the media for our position was very gratifying, with several well written, thoughtful editorials in major newspapers. We are sincerely appreciative of Governor Nigh's wisdom in vetoing this bill.

However, we must not simply reflect pleasantly on this success. We must learn from it. What, then, appear to be the major lessons?

First of all, a very basic grassroots involvement in the election of our legislators, and absolutely essential support of OMPAC are the foundation stones on which any successful legislative effort is based. The misconception of Oklahoma physicians as a single interest group acting only for their personal economic betterment is still widespread among many in the political process.

Secondly, we must realize that the most knowledgeable, scientific testimony and the most thorough daily efforts at reasonable lobbying may simply not be sufficient. The very nature of compromise in the legislative process is such that scientific testimony simply may not prevail as legislation is drafted, amended, and modified by both houses of this legislature and by conference committees.

Finally, we should realize that our carefully focused efforts can be highly effective. However, the significance of the particular legislation must be properly evaluated in determining the type of action appropriate for our association. Judgments are necessarily subjective in this area, but we cannot be exclusively arbitrary and negative. This particular veto is indeed a positive one, and we must now proceed with positive legislative efforts of our own.

George H. Kamp, M.D.

Medical and Social Aspects of the Nuclear Arms Race

LEWIS THOMAS, MD

Lewis Thomas, MD, is chancellor of the Memorial Sloan-Kettering Cancer Center in New York City. A distinguished physician, biomedical researcher, and best-selling author, Dr Thomas has served on the faculties of five schools of medicine and has been dean of both New York University-Bellevue Medical Center and the Yale University School of Medicine. He is a past member of the Harvard Board of Overseers and serves on the board of trustees of the Menninger Foundation, the Guggenheim Foundation, the General Motors Research Foundation, the Mt Sinai School of Medicine, and several other foundations and educational organizations. Dr Thomas also is a member of the National Academy of Sciences and a Fellow of the American Academy of Arts and Sciences and the American Philosophical Association. On May 19, 1983, he presented the Francis J. Reichmann Memorial Lecture at the University of Oklahoma Health Sciences Center. His subject was the "Medical and Social Aspects of the Nuclear Arms Race." This report highlights some of the major points Dr Thomas made in his address.

On basic research in the United States today: "Basic science has fallen on hard times in biology and medicine, even more so in physics and chemistry. Cosmology . . . is in the deepest trouble of all: all the opportunities to pursue the exploration of our solar system . . . are being set aside because of the money shortage. . . . There is one huge exception, an anomaly so enormous that it makes the whole policy look ridiculous . . . research on thermonuclear weapons."

On the billions of dollars being spent on nuclear weapons: "With that kind of money we could be building Scarsdales on Mars if we had a mind to. We could be gardening out in the galaxy. We could free ourselves, our animals, and all our vegetation from disease. We could solve our energy problems and learn how to clean up after ourselves on our own suburban planet. We could begin paying attention to all our children, everywhere on the globe, and their children still to come. We could even begin learning enough about each other to begin growing up as a species, liking each other, on the way to loving each other."

On the fundamental problem of nuclear weaponry: "If everyone agrees . . . that the weapons will never be let fly, never be used, never even be allowed out of the hatchways of

their silos, and if, at the same time, everyone agrees . . . that they are not only indispensable for our security but for the Soviets' security as well, then we are in the presence of a really great paradox . . . : a great truth for which the opposite is also a great truth."

On the specious nature of arguing acceptable nuclear war casualty figures: "One side says that 10 million quick civilian deaths represent acceptable damage considering what's at stake; the other side says that's not acceptable. The technical facts don't help here. It is not a scientific problem. . . . The numbers are simply too big for comprehension. There is even some risk that using such numbers — a hundred million deaths in 20 minutes under one scenario, only 10 million deaths in another — can introduce such a sense of unreality in the public mind that . . . we might suddenly, one day, be persuaded into a feeling of pride and exultation because the latest advance means that only 1 million of us will be vaporized in the next 20 minutes."

On contemplating the aftermath of thermonuclear war: "Words like *disaster* and *catastrophe* are too frivolous for the events that would inevitably follow a war with thermonuclear weapons. *Damage* is not the real term; the language has no word for it. Individuals might survive, but *survival* is itself the wrong word. As to the thought processes of the people in high perches of government who believe that they can hide themselves underground somewhere (they probably can) and emerge later on to take over again the running of society (they cannot, in the death of society), or, more ludicrous, the underground headquarters already installed in the mountains for corporate executives who plan to come out of their tunnels to reorganize the telephone lines or see to the oil business, these people cannot have thought at all."

On coping with the medical aspects of nuclear war: "The people in the Pentagon offices and their counterparts in the Kremlin where the questions of coping with war injuries are dealt with must be having a hard time of it these days, looking ahead as they must look to the possibility of thermonuclear war. Any sensible analyst in such an office would be tempt-

ed to scratch off all the expense items related to surgical care of the irradiated, burned, and blasted, the men, women, and children with empty bone marrows and vaporized skin. What conceivable benefit can come from sinking money in hospitals subject to instant combustion, only capable of salvaging . . . a tiny cluster of the victims who will be lying out there in the hundreds of thousands? There exists no medical technology that can cope with the certain outcome of just one small, neat, so-called "tactical" bomb exploded over a battlefield. As for the problem raised by a single large bomb . . . dropped on New York City or Moscow, with the dead and dying in the millions, what would medical technology be good for?

"Some of the physicians in this country and abroad [have been] forming organizations for the declared purpose of making it plain to everyone that modern medicine has nothing whatever to offer . . . in the event of thermonuclear war. . . . What they are beginning to try to tell the world, in the hope that their collective professional opinion will gain public attention and perhaps catch the ears of political and military leaders everywhere, is simply this: If you go ahead with this business, the casualties you will instantly produce are beyond the reach of any health care system, any medical technology. Since such systems here and abroad are based in urban centers, they will vanish in the first fire, but even if they were miraculously to survive, they could make no difference, not even a marginal difference."

On today's world leaders: "How is it possible for so many people with the outward appearance of steadiness and authority, intelligent and convincing enough to have reached the highest positions in the governments of the world, to have lost so completely their sense of responsibility for the human beings to whom they are accountable? Their obsession with stockpiling nuclear armaments and their urgency in laying out detailed plans for using them have, at the core, aspects of what we would be calling craziness in other people, under other circumstances. Just before they let fly everything at their disposal, and this uniquely intelligent species begins to go down, it would be a small comfort to understand how it happened to happen. Our descendants, if there are any, will surely want to know." □

Rabies in Oklahoma: Report of a Human Case

CHARLES G. HELMICK III, MD
ANDREW A. VERNON, MD
STANLEY S. SCHWARTZ, MD
MICHAEL WARD, MD
MARK ROBERTS, PhD

Human rabies has become an increasingly rare disease in the United States, with only one or two cases reported annually. This report describes medical aspects of a case of human rabies in Oklahoma in 1979, the first reported in this state since 1952, and the public health problems imposed by the theoretical risk of human-to-human transmission.

Overview

A 24-year-old man from Sapulpa, Okla, contracted rabies in September 1979. Prominent symptoms included confusion, hyperirritability, seizures, and diaphoresis. The patient died after 20 days, despite intensive hospital care.

Diagnosis was made by serology, corneal im-

pressions, fluorescent antibody staining of brain tissue, and isolation of virus from the brain. No specific therapy was given.

Fifty-seven contacts of this patient were given rabies prophylaxis because of the possibility that their open wounds or mucous membranes may have been contaminated by the patient's secretions.

No source for the patient's infection was found.

Case History

A married, 24-year-old, male woodcutter and handyman from Sapulpa was in good health until the night of September 15, 1979 (Day 1), when he experienced difficulty sleeping. Over the next two days he became ill with malaise, nausea, vomiting, headache, sharp abdominal pains, dysuria, and temperature of 101°F. He consulted his physician, who diagnosed a urinary tract infection when a urinalysis revealed 5-8 wbc/hpf and 2-5 rbc/hpf. Oral antibiotics were given, but his symptoms persisted.

On September 18 (Day 4), he was admitted to a local hospital complaining of myalgia and frontal headache; his abdominal pain had abated. His wife reported that he had been acting strangely for the past two days, and might

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have been hallucinating. Past medical history was remarkable for a 36-pound weight loss in the prior year, possibly from sharing his wife's "diet pills." Physical examination revealed a confused, uncooperative, and anxious male with normal vital signs. There was mild injection of the tympanic membranes, mild anterior cervical adenopathy, bilateral costovertebral angle tenderness, and mild abdominal tenderness with no peritoneal signs. Complete blood count, urinalysis, chest X ray, electrocardiogram, and serum electrolytes were within normal limits. Urine culture obtained on admission was negative for bacterial pathogens.

Over the next two days the patient noted increasing myalgias and a sore neck. His temperature rose to 102.2°F, and he experienced hydrophobia, hyperactivity, alternating periods of lucidity and confusion, copious diaphoresis, and a generalized tremor made worse by light or noise. The wbc count rose to 19,700 cells/mm³ with a leftward shift. Lumbar puncture revealed clear cerebrospinal fluid with 45 rbc and 0 wbc/mm³, glucose 87 mg/dl, and protein 111 mg/dl. Virtually every medical or nursing attendant commented upon the emotional aspect of his illness, because the patient not only was severely anxious himself in the early phase of his hospitalization, but also provoked anxiety among those caring for him.

. . . (Day 4) . . . Physical examination revealed a confused, uncooperative, and anxious male with normal vital signs.

On the evening of September 20 (Day 6), he suddenly became hypotensive and unresponsive, vomited coffee-ground material, and experienced right-sided seizures. He required intubation because of hypoxemia ($pO_2 = 58$ mm, $pCO_2 = 32$ mm, $pH = 7.44$ on room air) and inability to manage copious oral secretions. His seizures were poorly controlled with medications, and became generalized and recurrent the following day. Temperature rose to 103.4°F, and a peripheral left seventh cranial nerve palsy and bilateral Babinski reflexes developed.

Early on September 22 (Day 8) the patient was transferred to a large hospital in Tulsa. On admission he was unresponsive, diaphoretic, and seizing. His pulse rate was 130/minute, the blood pressure 100/60 mm Hg on intravenous dopamine, the respiratory rate 14 on ventilatory support, and the temperature 104.0°F p.r. HEENT exam showed injected sclerae and optic discs that were poorly seen. Tympanic

. . . (Day 8) . . . Initial diagnosis in the referral hospital was "acute infectious illness with cerebritis, suspect bacterial endocarditis."

membranes and oropharynx were normal. The neck was supple and no significant adenopathy was noted. There were scattered rhonchi on auscultation of the chest. The heart sounds were distant, with a systolic ejection murmur present. The abdomen was examined and found to be normal. There were scattered ecchymoses over the extremities. The patient was unresponsive to voice commands and exhibited no purposive movement. The right pupil measured 4 mm in diameter, the left pupil 3 mm, and the reaction to light was sluggish. The corneal reflex was absent on the right. The Doll's eyes response was absent. A peripheral left seventh nerve palsy was still present. There was small-amplitude jerking of the upper extremities and the head. Painful stimuli such as pinch or sternal rub resulted in increased amplitude and frequency of jerking. Deep tendon reflexes were absent and bilateral Babinski reflexes were present.

Laboratory tests were remarkable for elevated BUN, creatinine, uric acid, amylase, creatine phosphokinase, and SGOT (Table 1). Serum calcium was low, and serum phosphorus and magnesium were high. A computerized tomographic scan of the head revealed air/fluid levels in the ethmoid and sphenoid sinuses, but was otherwise normal. A skull X ray showed only the same air/fluid levels. An isotopic brain scan was negative. On lumbar puncture, the opening pressure was 125 mm Hg with elevated white cells and protein (Table 1). Electroencephalogram revealed a diffuse, slow, non-focal dysrhythmia. Echocardiogram showed normal mitral and aortic valves and a normal contracting left ventricle.

TABLE 1.
Selected Laboratory Results, Human Rabies,
Oklahoma, September 1979

Test	Day of Illness	Result	Comment
Chemistry			
albumin, serum	6	4.7 g/dl	Normal 3.5-5.5; no urinary protein measures
	8	3.4	
	13	2.4	
amylase	8	284 Somogyi units	Normal 60-180
BUN	8	44 mg/dl	Normal 10-20
calcium	8	7.8 mg/dl	Normal 9-11
creatinine			
phosphokinase	7	4,370 U/ml	Normal 0-225; all MM isoenzyme
	8	26,244 U/ml	
creatinine	8	4.7 mg/dl	Normal 1.0-1.5
magnesium	8	3.2 m Eq/L	Normal 1.5-2.5
phosphorus	8	5.7 mg/dl	Normal 3-4.5
SGOT	8	390 IU/L	Normal 3-26
uric acid	8	12.8 mg/dl	Normal 2.5-8.0
electrocytes,			
glucose,	8	nl	
total protein,			
albumin	8	nl	
bilirubin	8	nl	
alkaline			
phosphatase	8	nl	
serum ammonia	8	nl	
Hematology			
Hct	8	42% Hgb (14 mg/dl)	
Wbc	8	14,300 (94% neutrophils, 2% bands)	
platelets	8	138,000	
prothrombin			
time	8	nl	
partial			
thromboplastin	8	nl	
time			
fibrinogen	8	nl	
Serology			
hepatitis B			
surface	8	neg	
antigen			
rheumatoid			
factor	8	neg	
antinuclear			
antibody	8	neg	
febrile			
agglutinins	8	neg	
Other lab			
EKG	8	sinus tachycardia	
CXR	8	nl	
Urinalysis	4	Normal	
	6	2-4 wbc, 2+protein	
	7	20-30 rbc, 3-5 wbc	
	11	2+ blood, 1+ protein	
Cerebrospinal			
fluid	6	0 wbc, 45 rbc, protein 111 mg/dl, gluc 87 mg/dl	Normal CSF pro- tein 15-40 mg/dl
	8	35 wbc (34 lymphs, 1 mono), protein 176 mg/dl, gluc 133 mg/dl	

Initial diagnosis in the referral hospital was "acute infectious illness with cerebritis, suspect bacterial endocarditis." Initial antibiotic treatment included nafcillin, gentamycin, and chloramphenicol. Cultures of blood, urine, endotracheal aspirate, and cerebrospinal fluid remained negative. Repetitive seizures were treated with intravenous phenytoin and diazepam, and intravenous dexamethasone and cimetidine were administered. Vasopressor

support of the patient's blood pressure was continued. On September 26 (Day 12), strict isolation precautions were instituted. Over the next several days, seizures stopped, but the patient remained unresponsive. His moderate renal failure did not improve, and creatinine varied from 3.3 to 5.0 mg/dl. A transient pericardial friction rub was heard, and the EKG showed ST segment elevations consistent with pericarditis; both resolved.

The patient's subsequent course was complicated by recurrent melena, anasarca, and autonomic instability manifested by severe diaphoresis and marked fluctuations in body temperature (35 to 41° C p.r.). On October 1 (Day 17), he developed evident diabetes insipidus, with a urine output of over 20 liters in 24 hours, serum osmolality 350 mosm/kg H₂O, and urine osmolality 219 mosm/kg H₂O. He showed a prompt response to intramuscular vasopressin, with a 90% reduction in urine output. On October 4 (Day 20), he suddenly developed a complete heart block and died despite resuscitative measures. No rabies immune globulin nor vaccine had been given.

Rabies Diagnostic Examination

The diagnosis of rabies was first considered on September 26 (Day 12). Corneal impression tests performed on that day and serum specimens drawn on September 22, 23, and 24 (Days 8, 9, and 10) were shown to be positive for rabies antigen and antibody at the Centers for Disease Control (CDC). Because the rise in serum neutralizing antibody was unusually slow and occasional false-positives are seen with the corneal impression test, confirmation of the diagnosis was sought. A limited post-mortem examination was performed, with appropriate precautions, by personnel not immunized against rabies. Through a burr hole in the posterolateral skull, six brain biopsies were obtained using a Silverman needle. A portion of parotid gland was dissected.

Rabies diagnostic results are summarized in Tables 2 and 3. Postmortem histopathologic examination of brain tissue revealed an occasional perivascular lymphocytic infiltrate. A single neuron in one of three sections contained an oval eosinophilic cytoplasmic inclusion compatible with that of a Negri body.

Epidemiologic Investigation

The patient's family and friends were interviewed regarding his lifestyle, habits, and possible exposure to animals in the preceding 18

months, and his home and work sites were visited. He had lived with his wife and three children in a residential neighborhood of Sapulpa for the prior 18 months. Previously he lived in rural Arkansas. He had no long-term occupation, but had worked energetically at a wide variety of unskilled jobs. In the preceding 6 months he had worked as a firewood cutter and clean-up man at construction sites in Creek County. The former task frequently took him to areas of light forest and scrub vegetation where opportunities for contact with small wild animals were numerous. He undertook occasional spelunking, last exploring a cave in 1976 in Arkansas, where his family had occasionally observed bats. In 1975 he had visited the Texas-Mexico border area, known for a high rate of domestic animal rabies, but he had no known exposure at that time.

Pets (two dogs, one cat) were immunized and showed no signs of illness. There was no evidence of bats in the vicinity of the patient's house. The only known animal bite was a nip by a neighbor's dog in early September, but the dog had been appropriately immunized against rabies and developed no subsequent illness. A saliva sample from the dog obtained four weeks after the bite yielded no rabies virus by mouse inoculation testing at CDC. No source for this man's infection was found.

Screening and Prophylaxis of Exposed Persons

Personnel at both hospitals who had been in contact with the patient were asked to fill out a

TABLE 2.
Antibody Data from Rabies Case,
Oklahoma, September 1979

Day of Illness	Neutralizing Antibody Titers*
Serum	
8 (Sept 22)	1:12
9	1:10
10	1:14
14	1:40
15	1:54
16	1:33
17	1:50
18	1:56
19	1:56
Cerebrospinal Fluid	
9	Less than 1:2
113	Less than 1:2

*Rapid Fluorescent Focus Inhibition Test

questionnaire about the type of contact they had sustained. Close friends and family were similarly questioned about contact with the patient between September 8 and October 4. Persons indicating possible exposure were individually interviewed. They were advised to receive post-exposure prophylaxis (PEP) if they gave a history of having open wounds or mucous membranes exposed to the patient's respiratory secretions or saliva, or if they had used drinking or eating utensils immediately after the patient, or if they had sustained a needle-stick exposure. At the hospital in Tulsa, 205 employees had some contact with the patient and completed questionnaires; 125 were interviewed, and PEP was recommended for 22. At the hospital in Sapulpa, 408 employees had some contact with the patient and filled out questionnaires; 87 were interviewed, and PEP was recommended for 12. Approximately 40 family and personal contacts were interviewed, and PEP was recommended for 23. PEP in all cases consisted of standard doses of human rabies immune globulin plus five doses of human-diploid-cell rabies vaccine (provided by Wyeth Laboratories) spaced over 28 days.

Of the 34 hospital employees receiving PEP, 30 were treated for saliva exposure to open wounds or mucous membranes, and 4 for needle-sticks. Of these 34, 12 were nurses or nurse's aides, 7 were respiratory therapists, and 5 were physicians.

Costs

The hospital bill accrued by the patient was \$22,575. The cost of 57 doses of human rabies immune globulin, assuming an average weight of 50 kg per contact, was \$7,600. The manufacturer kindly provided vaccine at no charge; otherwise, cost of the vaccine would have been \$11,400. Personnel costs exceeded \$4,000. Costs of administering vaccine, managing reactions, and conducting laboratory investigations at CDC were not tabulated. Nonetheless, the cost resulting from this case was estimated to be over \$45,000. Substantial savings would have resulted if the patient had been placed in strict isolation earlier in the course of his disease.

Discussion

The diagnosis of rabies in this instance was confirmed by isolation of virus from the patient's brain tissue. Serum neutralizing antibody showed a greater than fourfold rise,

TABLE 3.
Rabies Diagnostic Data on Patient's Tissues/Fluids,
Oklahoma, September 1979

Tissue	Fluorescent Antibody Staining	Mouse Inoculation Test* (for virus isolation)
Corneal Impression (D 12, 19)	Positive	ND
Conjunctival Washing (D 12, 19)	ND	Negative
Urine (D 12)	ND	Negative
Sputum (D 13)	ND	Negative
Stool (D 13)	ND	Negative
Oral Secretions (D 15, 19)	ND	Negative
Brain (postmortem needle biopsies, D 20)	Positive	Positive
Parotid gland + (postmortem biopsy, D 20)	Negative	Negative

* Fluorescent antibody confirmation of mouse brain

+ Presumed parotid gland, histologic examination not performed

D = Day

ND = Not Done

but remained relatively low, possibly because parenteral corticosteroids were administered throughout the patient's illness.¹ Cerebrospinal fluid (CSF) rabies antibody is usually detectable after Day 10 of illness, but was absent when measured on Days 9 and 13 in this patient. The factor responsible for the sluggish serum antibody response may also account for this suppression or delay in CSF antibody response.

This was the first case of human rabies reported from Oklahoma since 1952. In that year, two cases occurred in Oklahoma: one in an 11-year-old boy exposed to a skunk in California, and the other in a 43-year-old woman, also a resident of Creek County, who presumably acquired infection from her rabid dog.

The patient's clinical course was typical of human rabies, with a non-specific prodromal stage, an acute neurologic stage, coma, and finally death.² The multiple complications (diabetes insipidus, seizures, hypoxemia, respiratory arrest, cardiac arrhythmia, hypotension, and gastrointestinal bleeding) were also typical.^{2,3} However, several aspects of this patient's illness were unusual. Dysuria, one of his early complaints, is uncommon, although Baraff⁴ reported dysuria in a 15-year-old girl and Dupont⁵ noted urinary tract infection as an occasional initial diagnosis. This symptom may be related to neuritic pain or actual viral infection of the genitourinary tract. The

sphenoid and ethmoid air/fluid levels may have represented a sinusitis resulting from a traumatic nasopharyngeal intubation. Pericardial rub, noted by two observers during the hospital course, has not been reported with human rabies. It may have been due to viral infection of the myocardium (myocarditis has been reported) with inflammation of the adjacent pericardium. Acute renal failure has not been reported with rabies; in this instance it may have been due to prolonged hypotension and/or continued use of high doses of dopamine to maintain adequate blood pressure. Abnormalities of CPK and SGOT were probably due to sustained seizures and muscle damage, but the reason for other abnormal serum chemistries is unclear.

The source of this man's infection remains unknown despite careful questioning of family and friends. Between 1966 and 1981, no source of infection could be discovered in 7 (23%) of the 30 cases of human rabies reported to CDC. Dupont,⁵ in his series of 49 case records, found 19 (39%) persons without a history of animal exposure despite otherwise adequate clinical records. The absence of a history of animal exposure in this case was likely due to the patient's inability to communicate, since the diagnosis was not considered until he was comatose. Possible modes of exposure could have been an animal bite which he felt to be minor; an animal bite acquired unknowingly (eg, a bat bite while he was asleep); an animal bite resulting in a disease with a very long incubation period, precluding recall; or a non-bite exposure.

Even with a history of animal exposure, rabies hysteria and postvaccinal neurologic reactions must be considered in the differential diagnosis.

The diagnosis of rabies can be difficult in the absence of a history of animal exposure. Initial diagnoses have included other viral encephalitides, Guillain-Barre syndrome, poliomyelitis, tetanus, schizophrenia, drug overdose, and endocarditis. Even with a history of animal exposure, rabies hysteria and postvaccinal neurologic reactions must be considered in the differential diagnosis. Early diagnosis is difficult since specific antibody

may not be present before the tenth day of illness. Experimental techniques, such as fluorescent antibody staining of corneal impressions and neck skin biopsies, show some promise for earlier diagnosis. Treatment of persons clinically ill with rabies is supportive at present, though interferon is being used experimentally in some cases.

The risk of acquiring rabies through contact with a rabid human is theoretical, since there has been no well documented human-to-human transmission³ other than that which has occurred following corneal transplants.^{7,8,9} However, rabies virus has been isolated from human saliva,^{4,10} urinary sediment,¹⁰ respiratory secretions,¹⁰ nasal swabs,⁴ pharyngeal swabs,^{4,10} brain,^{4,10} eye,^{7,10} CSF,¹⁰ tears,³ peripheral nerve,¹¹ and various viscera, including heart, kidney, lung, liver, and skeletal muscle.¹¹

In prior cases of human rabies, recommendations for rabies post-exposure prophylaxis for hospital personnel and personal contacts have varied from treating as few as 2⁴ to as many as 186.⁶ The intense degree of dread which this disease arouses probably accounts for a significant number of courses of PEP administered. Many persons who are uncertain of the precise circumstances of their exposure will elect to undergo PEP. As in this case, negative cultures of a patient's oral secretions do not eliminate the theoretical risk of virus transmission, since such secretions will be positive only intermittently.

Though the patient had numerous social contacts and professional contacts at both hospitals during his illness, a program of education and individual evaluation of exposure to the patient prevented a great deal of unnecessary rabies prophylaxis. Such efforts kept the already high costs of this illness from rising still further.

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Rabies in Oklahoma: An Epidemiologic View of the Problem in Animals

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Analysis of statewide surveillance data on animal rabies may disclose means to control better this increasing public health problem. Active approaches are needed.

Animal rabies remains a substantial public health problem in Oklahoma. It is responsible for human suffering as a consequence of reactions to post-exposure prophylaxis (PEP); for expense due to cost of prophylaxis, laboratory maintenance, and loss of economically valuable domestic animals; and on rare occasions, for human deaths (the most recent in 1979 and 1981).^{1,2} In the past 30 years, Oklahoma, like many other areas of the United States, has had

a major increase in reported skunk rabies and major decreases in reported domestic animal and human rabies.³ Whether the former change reflects actual changes in the epidemiology of animal rabies or is merely due to changes in reporting and testing practices is uncertain. This report reviews reported animal rabies in Oklahoma as well as the use of post-exposure prophylaxis and makes recommendations for rabies control and prophylaxis.

Methods

In the 1970s, the Virology Division of the Oklahoma State Department of Health (OSDH) Laboratory Service was the only laboratory in the state testing animal specimens for evidence of rabies virus. To be tested, specimens had to be accompanied by a report indicating that human or animal exposure to the examined animal had occurred. These specimens were examined free of charge. Since 1973, it has been laboratory policy to refuse examination of cage-raised rodents, since rabies in such animals appears to be extremely rare in the United States.³ All specimens were examined by the fluorescent rabies antibody (FRA) test, using impression smears obtained from standard brain structures.⁴ Since 1974,

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brain tissue from large animals (ie, horses, cattle), was also inoculated into mice to augment testing sensitivity.

To estimate the 1978 rate of anti-rabies vaccination of humans in Oklahoma (post-exposure prophylaxis, or PEP), data on sales to Oklahoma purchasers of human rabies immune globulin (HRIG) — which is used only for PEP and not for pre-exposure immunization — were used. These data were provided by the only 1978 US supplier of that product. To calculate an estimated number of PEP courses, the then-current recommendation⁵ of 0.133 cc/kg was used, and it was assumed that the average recipient weighed 65 kg.⁶ Data on sales of duck embryo rabies vaccine (DEV) and HRIG in 1978 were provided by the pharmaceutical wholesaler which handled 50% of the HRIG sold to Oklahoma purchasers. Use of human-diploid-cell strain rabies vaccine (HRV) was ignored, since it was not commercially available in 1978, and since it accounted for less than 10 courses of PEP in Oklahoma that year. No other rabies vaccine was available for human use in Oklahoma at that time. Cost estimates were based upon 1978 wholesale prices of pharmaceuticals. Comparison data were obtained from three other states that absorbed the cost of PEP for state residents.

Results

From 1971 through 1979, 25,187 animal specimens were tested for rabies and 1,985 (7.9%) were positive (Table 1, Figure 1).

Table 1.
Results Animal Specimens Submitted to the
Oklahoma State Department of Health for Rabies Testing, 1971-1979

Species	Number Submitted (%)	Number Positive (%)	Positivity Rate
Skunk	2,983 (11.8)	1,479 (75.0)	49.6%
Cattle	1,419 (5.6)	266 (13.4)	18.7%
Dog	7,375 (29.3)	55 (2.8)	0.7%
Cat	7,482 (29.7)	97 (4.93)	1.3%
Bat	655 (2.6)	47 (2.4)	7.2%
Horse	131 (0.5)	21 (1.1)	16.0%
Raccoon	492 (2.0)	4 (0.2)	0.8%
Coyote	192 (0.8)	5 (0.3)	2.6%
Opossum	402 (1.6)	1 (0.1)	0.3%
Sheep/Goat	36 (0.1)	3 (0.2)	8.3%
Fox	40 (0.2)	5 (0.3)	12.5%
Mouse, rat, squirrel, gerbil, guinea pig, gopher, mole, shrew, ground squirrel, hamster and rabbit	3,555 (14.1)	0 (0.0)	0%
Other	425 (1.7)	2 (0.1)*	0.5%
ALL	25,187 (100.0)	1,985 (100.8)	7.9%

*(1979: 1 bobcat, 1 human)

Table 2.
Animal Rabies and Post-Exposure Prophylaxis
in Oklahoma and Three Other States, 1978*

	Okla.	Iowa	N. Mexico	Georgia
No. rabid animals	194	147	25	290
No. rabid skunks	146	76	14	6
No. rabid raccoons	0	0	0	249
No. rabid dogs	8	11	0	4
No. rabid cats	6	18	2	3
No. PEP given	250†	107	32	99
1978 population (10 ⁶)	2.880	2.896	1.212	5.084
Rabid animals/ 10 ⁵ pop.	6.74	5.08	2.06	5.70
PEP/10 ⁵ pop.	8.68	3.69	2.64	1.95
PEP/No. rabid animals	1.29	0.73	1.28	0.34

* Data on numbers of rabid animals taken from Center for Disease Control: Reported Morbidity and Mortality in the United States, 1978. Data on number of courses of PEP was provided by the Health Departments of the respective states. Populations given are for 1978, from US Bureau of the Census, Current Population Reports, Series P-25.

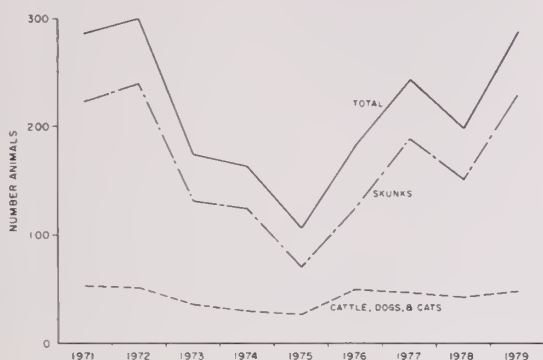
† Estimated (see text).

Skunks accounted for only 11.8% of all specimens tested but for 75.0% of all positive specimens. The positivity rate (number positive divided by number tested) for skunks was 49.6%. Bats accounted for 2.6% of specimens examined and for 2.4% of positive specimens. Cats and dogs accounted for 59.0% of specimens tested, but for only 7.7% of positive specimens, with a positivity rate of only 1.0%. During these years, rabies was also confirmed in goats, foxes, raccoons, coyotes, sheep, an opossum, a bobcat, and a human. Examination of rodents and other small animals yielded no positives in these nine years, although over 3,500 such animals were tested.

Monthly data on submission and positivity were available for the years 1974 through 1979. While the numbers of both examined and positive skunks exhibited relative increases in the spring and the autumn (Figure 2), positivity rates remained relatively constant throughout the year (range 43.0% to 58.0%). The monthly pattern of reported bovine rabies exhibited an annual peak in the spring, following the peak in skunk rabies by one to two months (Figure 3). The bovine peak remained constant in magnitude, however, despite year-to-year variation in the height of the skunk peak. Reported bat rabies, on the other hand, exhibited a peak in late summer and early autumn, with 25 (80.6%) of the 31 positive bats in these six years reported in the months of August, September, and October. No positive bats were reported in the six-month period November through April, but few specimens were submitted for testing in those months.

Rabies in dogs and cats is of particular interest since exposures to these species account

Fig 1 REPORTED RABID ANIMALS, BY YEAR AND TYPE, OKLAHOMA, 1971-1979

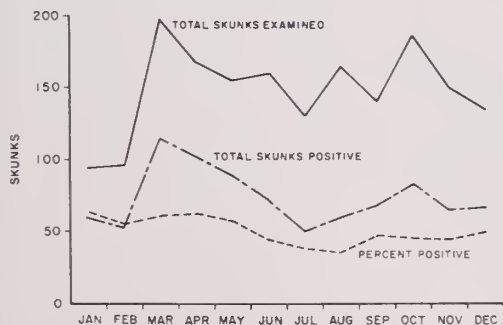


for the majority of anti-rabies treatments of humans. Submission rates for dogs and cats were greatest during the months May through August; numbers of positive specimens and positivity rates were greatest in the period April through July.

Confirmed animal rabies occurred statewide, but focal concentrations of reported skunk rabies were noted (Figure 4). Fifty-one (66.0%) of 77 counties reported dog or cat rabies in those years (Figure 5), and 74 (96.0%) reported skunk rabies. The two counties with greatest population densities (Oklahoma and Tulsa) submitted large numbers of animals but had low positivity rates. The location of a county within the state did not correlate with submission or positivity rates.

Enough HRIG to treat 250 persons was sold to Oklahoma purchasers in 1978. Oklahoma's estimated PEP rate of 8.7 per 100,000 population was 2.4 to 4.5 times greater than reported rates in the three comparison states of Georgia, Iowa, and New Mexico (Table 2). In 1978, PEP cost Oklahomans over \$55,000.

Fig. 2 RESULTS OF RABIES TESTING OF SKUNKS SUBMITTED TO STATE DEPARTMENT OF HEALTH LABORATORY, BY MONTH, OKLAHOMA, 1974-1979

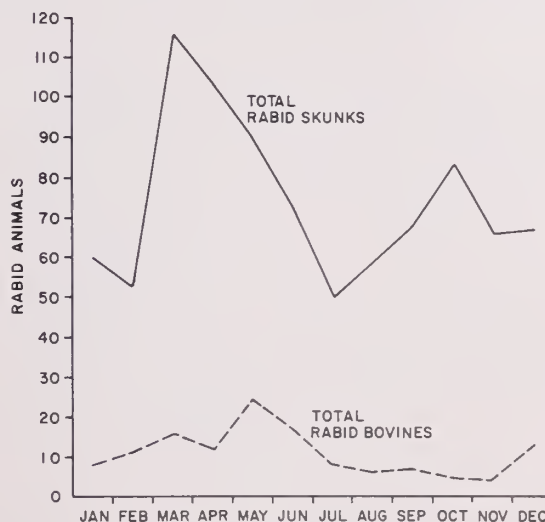


Discussion

The data on animal rabies must be viewed in light of the artifacts introduced by reporting practices. Specimens are accepted for testing only if the animal had potentially exposed humans or other animals. The likelihood of exposure is influenced by the densities of the animal and human populations and by the amount of interaction between the two groups. The perceived need for testing is influenced by the degree of suspicion (eg, distance to the laboratory), the nature and severity of the exposure (eg, bite vs non-bite), and the level of awareness of the problem (eg, publicity regarding recent exposures or concentration of professionals likely to encourage submission). Understanding of how the reported animal rabies rate relates to the actual rate is limited.

The various positivity and submission rates among different species reflect differences in reason for submission as well as differences in incidence. Some reports have suggested that reported skunk rabies reflects only a fraction of the total number of rabid skunks.⁷ Human exposure to cat and dog bites is frequent, resulting in high specimen submission rates and low positivity rates for these species. Large domestic animals, on the other hand, are costly and are less likely to expose humans. They are thus unlikely to be submitted unless exhibiting more typical signs of illness, resulting in higher positivity rates.

Fig. 3 REPORTED RABID SKUNKS AND BOVINES, BY MONTH, OKLAHOMA, 1974-1979



Despite the problems in interpretation, reporting of animal rabies is a worthwhile public health measure. In 1972, Lewis reported that skunk rabies in Oklahoma was found in environmental niches ideally suited for skunks.⁸ The seasonal trends in reported skunk rabies may be a consequence of greater skunk-to-skunk contact in the spring breeding and fall denning seasons.⁷ The Lewis study also suggested that the reported rate of domestic animal rabies was a reliable measure of the presence of wild animal rabies. The parallel noted in this study between skunk- and bovine-rabies peaks supports this finding. National reporting also indicates that states reporting more skunk rabies also report the majority of bovine rabies.³ The temporal relation of reported bovine and skunk rabies also supports the hypothesis that bovines are infected by skunks, since the 30 to 60 day lag between skunk and bovine peaks could represent the typical 30 to 60 day incubation period for rabies in bovines. Temporal data on dog and cat rabies suggest a similar temporal relationship with the occurrence of skunk rabies.

The differences in rates of PEP between Oklahoma and the other states are not easily explained by differences in total numbers of rabid animals nor in terms of the presence or absence of domestic animal rabies. Since all the comparison states provided biologicals at no cost to state residents, it was believed that

almost all instances of PEP came to the attention of state epidemiology programs, providing an opportunity for expert consultation. A system that makes expert consultation likely, such as is presently in each of the comparison states, may substantially reduce the PEP rate.⁹

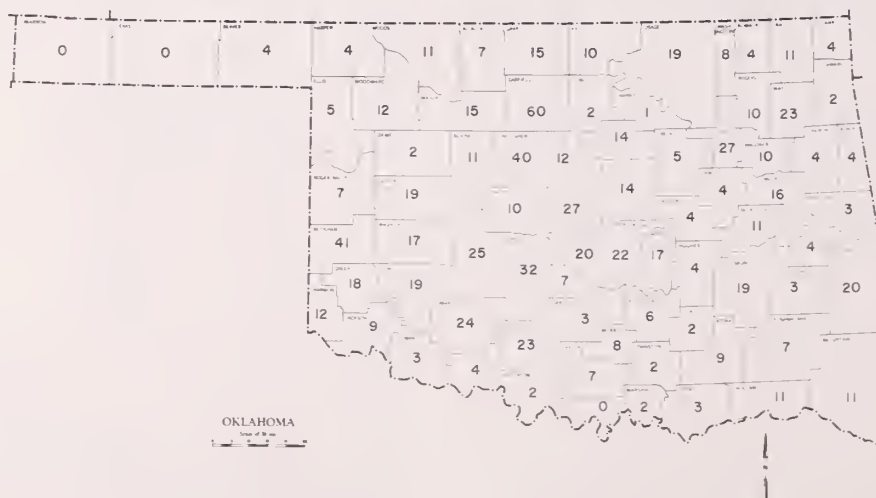
It is also possible that data from comparison states are incomplete, and PEP rates are higher than are reported. Although preliminary data from the national Human Rabies Prophylaxis Study (HRPS) indicate that over

The location of a county within the state did not correlate with submission or positivity rates.

90.0% of PEP includes HRIG currently,⁶ an estimate of PEP rate based on HRIG sales may not accurately reflect total PEP. Some HRIG may be lost, some may be discarded, and some may be used for PEP courses that are discontinued because a lost animal is found or because an animal is negative for rabies when tested in the laboratory. Counterbalancing these considerations is the likelihood that some Oklahomans obtain PEP in adjacent states.

A satisfactory estimate of the PEP rate for the United States is not available. The traditional estimate of 30,000 courses of PEP given

Fig. 4 TOTAL NUMBER REPORTED RABID SKUNKS, BY COUNTY, OKLAHOMA, 1974-1979



[illegible]

ment of complications, lost productivity, animal surveillance, and laboratory facilities. Recent cases of human rabies in Oklahoma have resulted in administration of PEP to over 200 persons exposed to the patients, and two persons have died.^{1,2}

1. *Control the major vector* (ie, limit the skunk population). There is no completely successful method for control of skunk populations, making vector control an unfeasible approach.⁷ Further, a moderate reduction in skunk population might lead to a substantial rebound in subsequent years unless the ecological vacuum created could be otherwise filled, or unless control measures could be sustained.

3. *Eliminate the disease in those species responsible for the majority of PEP recommendations* (ie, control rabies in dogs and cats). This approach is feasible if statewide immunization requirements for both dogs and cats are adopted and enforced.

Costs dues to rabies are significant; in 1978 PEP cost over \$55,000 for drugs alone, to which must be added costs of administration, treat-

sultation, such programs have been shown to reduce PEP rates in some states,⁹ while possibly not influencing them in others. Pilot efforts utilizing controlled availability of HRV are already underway through the Epidemiology Division, OSDH, and in many other states.

5. *Improve national and state surveillance of PEP.* Careful analysis of state and national surveillance data could reveal means to effect better control. Such surveillance could usefully include animal rabies data, information on PEP, and data related to the presence or absence of local animal control regulations. Already the distribution of HRV through state health departments is leading to the accumulation of some of these data. Oklahoma should participate actively in such efforts.

In summary, a passive approach to the problem of animal rabies in Oklahoma is unlikely to limit the morbidity and mortality caused by rabies. Solution requires more extensive surveillance and greater efforts at control, including through a PEP program coupled with expert consultation.

Acknowledgments

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Mark Roberts, PhD, adjunct professor, Department of Biostatistics and Epidemiology, University of Oklahoma, is a 1981 graduate of the University of Oklahoma College of Public Health. He is a member of the American Public Health Association and works with the Epidemiology Division of the Oklahoma State Department of Health.

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Herbert Beauchamp is employed in the Virology Division, Laboratory Service, Oklahoma State Department of Health. A 1956 graduate of the University of Kansas, he is a member of the Oklahoma Public Health Association.

Malaria

Each year many Americans travel to malarious areas of the world and are exposed to malaria, still a debilitating and occasionally fatal disease. Travelers are often unaware of the risk of acquiring malaria, of the severity of its complications, and of the protection afforded by malaria prophylaxis. Malaria attacks can be minimized by the use of relatively safe, convenient, and inexpensive prophylactic drugs taken as prescribed.

To reduce the risk of acquiring the disease, travelers can remain in well-screened areas or sleep under mosquito netting between dusk and dawn when the *Anopheles* mosquitoes are feeding. Exposure to mosquitoes outdoors can be reduced by wearing clothing that adequately covers the arms and legs and by applying mosquito repellent to thin clothing and exposed areas of the skin. The most effective repellent is N, N diethyl-meta-toluamide (deet), an ingredient of many commercially available insect repellents.

Malaria is transmitted in parts of Mexico, Haiti, Central and South America, Africa, the Middle East, Turkey, the Indian subcontinent, Southeast Asia, the People's Republic of China, the Malay Archipelago, and Oceania. The risk depends on the density and habits of the mosquito vectors, on the local weather, altitude,



News From The Oklahoma State Department of Health

and prevalence of the infection. When there is doubt regarding the risk, drug prophylaxis should be taken.

Patients should be advised that the onset of malaria can resemble an influenza-like illness. Fever accompanied by headache, arthralgia, and malaise may last for several days and only then progress to a more severe form of the disease.

Detailed information concerning malaria risk in individual countries and appropriate prophylaxis is published by the Centers for Disease Control in the publication *Health Information for International Travel*. A special malaria supplement to the Morbidity and Mortality Weekly Report published April 16, 1982, is a particularly useful update. Information concerning malaria can be obtained from the Preventive Medical Service, Oklahoma State Department of Health, P.O. Box 53551, Oklahoma City, OK 73152, (405) 271-4026. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR MAY 1983

DISEASE	MAY 1983	MAY 1982	APRIL 1983	TOTAL TO DATE	
				1983	1982
Amebiasis	—	1	2	4	6
Aseptic Meningitis	19	4	9	48	22
Brucellosis	1	1	2	3	4
Encephalitis, Infectious	2	3	3	9	11
Gonorrhea (Use Form ODH-228)	1,064	1,200	1,254	6,374	6,334
Hepatitis A	46	95	47	188	300
Hepatitis B	29	39	22	112	121
Hepatitis Unspecified	17	34	21	108	113
Malaria	1	3	—	6	3
Measles (Rubeola)	1	—	—	1	—
Meningococcal Infections	2	4	4	19	13
Pertussis	14	—	12	34	2
Rabies (Animal)	13	26	17	60	104
Rocky Mountain Spotted Fever	28	15	6	34	18
Rubella	—	—	—	—	2
Salmonellosis	34	25	31	164	82
Shigellosis	29	15	24	73	113
Syphilis (Use Form ODH-228)	15	15	32	113	80
Tetanus	—	—	—	—	—
Tuberculosis	28	39	38	125	158
Tularemia	2	2	4	6	4
Typhoid Fever	—	—	1	1	2



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The Roundtable: A Student's Point of View

REBECCA ADCOCK

Rebecca Adcock received a community medicine fellowship during her second year, University of Oklahoma College of Medicine.

One of her responsibilities during the year was to write the position paper for each Roundtable and to contact each speaker prior to the presentation.

Medical students kept within the bounds of the university hospital environment rarely have the opportunity to have contact with organized medicine and the physician in private practice. Frequently, the lack of exposure to practicing physicians makes the process of understanding the medical organization difficult. As a consequence, medical students often have little sense of the current medical issues which will suddenly face them as important concerns when they enter private practice.

Fortunately, the Oklahoma State Medical Association recognized this need for students of the University of Oklahoma College of Medicine to have some "real-world" physician contact and exposure to organized medicine. In

the spring of 1982, the Oklahoma State Medical Association approached the Division of Community Medicine, Department of Family Medicine, with an offer to co-sponsor and develop an experimental educational seminar series designed to meet the medical students' concerns about their lack of exposure to various aspects of medicine and public policy.

Ms Anita Delaporte, Director of Communications for the Oklahoma State Medical Association, along with Dr Wilson D. Steen, head of the Division of Community Medicine, Department of Family Medicine, proposed that a formal seminar series be developed, based on

From the list of suggested topics, a new approach to teaching medical students came into being in the form of a series of "Lunchtime Roundtable Discussions on Medicine and Public Policy."

current medical issues and public policy. Dr Steen, who leads a small group discussion for twenty first-year medical students enrolled in the course Patient Contact I, questioned his students about such an idea and received a favorable response. This same group of students met with Dr Steen and Ms Delaporte at a later date to generate topic ideas for the seminar series.

From the list of suggested topics, a new approach to teaching medical students came into being in the form of a series of "Lunchtime Roundtable Discussions on Medicine and Public Policy," held during the 1982-1983 academic year. Specific topics for the sessions were chosen during the summer months by Ms Delaporte, Dr Steen, and MSII Becky Adcock, who was a member of the original group of students presenting topic ideas. Ms Adcock received a fellowship from the Division of Community Medicine, Department of Family Medicine, to staff the project as a part of her fellowship arrangement. Those topics selected for discussion were: *An Inside Look at Rural Medicine; How Hospitals Work; Physicians and the Legislative Process; Technology in Medicine; Opening a Medical Practice; Where Business and Medicine Meet; and Membership in the Oklahoma State Medical Association.*

Seminar leaders were recruited from experienced practicing physicians who are active in organized medicine in Oklahoma. They included Dr Jack Parrish, Dr Kin Pirtle, Dr William Hughes, Dr Tom Lynn, Dr Steve Burner, and Dr John McIntyre. Some physicians were paired with a co-leader who works as a staff member for a medical specialty organization. They were Mr Charles Johnston, Vice-President, Oklahoma Hospital Association; Mr Lyle Kelsey, Associate Executive Director and Legislative Liaison, Oklahoma State Medical

Seminar leaders were recruited from experienced practicing physicians who are active in organized medicine in Oklahoma.

Association; Mr Ed Kelsay, Associate Director and Legal Counsel, Oklahoma State Medical Association; and Mr David Bickham, Executive Director, Oklahoma State Medical Association. Prior to each session, speakers were personally contacted by Ms Adcock in order to provide a better relationship between the speaker and student, thus serving to enhance the informality of the roundtable discussions.

Ms Adcock prepared a position paper on each of the six topics and these were distributed to all students prior to the presentation at the

Lunchtime Roundtable Discussion. Each speaker was given the opportunity to review and edit the paper prior to its circulation.

The program was offered to all students enrolled in the University of Oklahoma College of Medicine who were interested in learning about and becoming a part of medicine's role in the conduct of health affairs. A series of six discussion sessions was presented, meeting once a month at the Faculty House at 11:30 AM and including a buffet lunch, courtesy of the Oklahoma State Medical Association. Leaders for the sessions presented an opening statement which then became the basis for a roundtable discussion. Sessions adjourned at 12:50 PM, so that students could attend their afternoon classes.

. . . Students are receptive to the objective . . . to stimulate their thinking about real-world situations they may face as physicians.

Due to the nature of the sessions, enrollment was limited to twenty persons. In order to give students an equal opportunity for placement in the program, they were asked to submit applications from which participants were selected by lottery. Approximately 50 persons applied and names were drawn from each class in proportion to the number in each class that applied. Among the 20 students chosen, there was one MSIV, two MSIIIs, four MSIIIs, and 13 MSIs. Fifteen of the participants were male, and five were female. Also attending the sessions as special guests were Ms Delaporte; Dr Steen; Dr Charles McCall, Dean of the University of Oklahoma College of Medicine; Dr Ed Young, Dean of Student Affairs; and Dr Virginia Nunn, Dean of Academic Affairs. MSII Becky Adcock served as coordinator for the luncheons and introduced the seminar leaders.

At the last lunchtime roundtable discussion, students were asked to complete an evaluation of the series. Fifteen responded and all were very positive and enthusiastic about the roundtable discussion experience, which suggests that students are receptive to the objective of the series: to provide them with insight into the structure of organized medicine and to stimulate their thinking about real-world situations they may face as physicians. Espe-

cially well received was the opportunity to meet off-campus and outside of the classroom didactic teaching structure.

The group discussions that developed between the students and the roundtable leaders were informative and truly informal, which was a desired goal. The students asked questions and discussed their own reactions to the subjects and issues presented. Many of the topics were entirely new to the large number of MSIs, and the upperclassmen enhanced the learning experience by having enough previous knowledge about the topic to begin a discussion and speak freely with their fellow classmates.

Of those topics covered by the roundtable series, students indicated they would like to know more about opening a medical practice. Additionally, they listed topic ideas for future discussion, including a wide variety of ethical, social, and business-related issues. All of the students indicated a desire to attend the next series of roundtable discussions. Roundtable leaders, when first asked to lead a discussion group, were very receptive to the idea and encouraging to the planners of the series. Their reactions to the students were favorable, as shown by their willingness to be honest about their work situations and to stimulate an active discussion. Many students lingered after the luncheons to speak more extensively with the discussion leaders.

The University of Oklahoma College of Medicine administrators were also very supportive and enthusiastic about the series. Dean Young endorsed the program in its initial stages and provided feedback during its conception and implementation. Deans McCall, Young, and Nunn were able to attend one or more of the sessions.

As simple and informal as the roundtable discussions were, the series was not without a few problems. Dates for the luncheons were chosen according to the MSI and MSII lecture and exam schedules, which posed a conflict for some upperclassmen and also at times for the underclassmen, as their schedules were subject to change. However, the scheduling conflicts were inevitable and despite this, attendance averaged 75%, or 15 students at every session. It has been suggested that any future series be expanded to an enrollment of 25 in hopes of attendance by 20 persons.

The Medicine and Public Policy Lunchtime Roundtable Discussion series was a successful experience. Its success indicates that the Oklahoma State Medical Association was able to introduce medical students to aspects of medical practice not covered in their regular course of study and provide them with an opportunity to explore their concerns relating to their role in organized medicine as practicing physicians. □

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Travelers Abroad Poorly Advised About Health

United States citizens traveling abroad rarely protect themselves against disease and "unappreciated dangers" that lurk in many foreign lands, says Jonathan M. Mann, MD, MPH, of the New Mexico Health and Environment Department. Travelers can contract sometimes fatal illnesses because they are unthinkingly accustomed to safe water, food, and swimming areas, and they typically view mosquitoes and dog bites as minor nuisances, according to the specialist in emporiatrics, the science of the health of travelers.

Although approximately five million Americans visit the "tropics" and three million visit Mexico each year, many of these travelers as well as their physicians "lack both adequate background knowledge and current information about each of these areas," he says. Mann cites studies showing that more than 20 percent of international travelers experience at least one illness abroad. From 1970 to 1980, nearly 2,000 US travelers acquired malaria and 27 of these people died. Studies estimate that 30 to 36 percent of US travelers to Mexico experience travelers' diarrhea.

"In most cases, recommended medical interventions are more important in protecting travelers' health than the required vaccinations," Mann continues. "Examples of these often vital yet optional interventions include malaria chemoprophylaxis, . . . hepatitis A prophylaxis . . . typhoid or polio vaccine, and . . . rabies preexposure prophylaxis."

Mann suggests also that travel agencies and common carriers supply international travelers with information regarding health care abroad. □

Medmark Directory Unsanctioned By OSMA

A company operating as the Medmark Publishing Company is currently planning to produce a national directory of health care providers (MDs, DOs, dentists, DPMs, and DCs) and is soliciting listings from Oklahoma doctors.

Doctors should be aware that the publication has not been approved or sanctioned by the Oklahoma State Medical Association (OSMA), the American Medical Association (AMA), or any leading physician organization.

The recognized directories for physicians are the county medical societies' directories, the OSMA's directory, and the AMA directory. □

White Blood Cell Fragment May Be New Cell Type

Somewhat in the manner of physicists, hematologists are always on the trail of new particles. A team from Chapel Hill, North Carolina, recently uncovered a new white blood cell fragment that may be a full-fledged cell playing an important role in the immune response.

The investigators, Jacob S. Hanker, PhD, and Beverly Giammara, MS, from the University of North Carolina, Chapel Hill, say that neutrophil pseudoplatelets appear to be formed by "budding" from neutrophils — larger white blood cells that seek out and destroy bacteria and other foreign particles.

The neutrophil pseudoplatelet, so named because it acts like a neutrophil and looks like a blood platelet, can confuse automated blood analyzers into reporting a falsely high platelet count. In patients with acute myelogenous leukemia, who often have more neutrophil pseudoplatelets than platelets after a severe infection, this confusion can prevent diagnosis of a bleeding problem, say Hanker and Giammara. For these patients, chemical tests differentiating between platelets and neutrophil pseudoplatelets can provide a more accurate representation of blood status.

The two researchers think the small neutrophil pseudoplatelet may be able to infiltrate tissues that are inaccessible to the larger neutrophil.

Formation of neutrophil pseudoplatelets may be the end stage of neutrophil development, say Hanker and Giammara. They expect future research to determine that these particles are, in fact, full-fledged cells. □

Erratum: In the July issue of *The Journal* the headlines on page 188 and page 190 were inadvertently transposed by the printer. The *Journal* staff regrets the error and extends its apologies to Dr Kamp and Dr McIntyre and to our readers for any confusion that may have resulted.

Correctional Health Care Programs Receive Attention

In related activities recently, the American Medical Association has announced the expansion of its Jail Health Care Accreditation program and the organization of a new National Commission on Correctional Health Care.

The Jail Health Care Accreditation program, originated by the AMA in the mid-1970s, is aimed at improving medical services and health care conditions in the nation's jails. The recent expansion will include prisons and juvenile facilities as well. There are currently more than 400 jails participating in the program.

The newly formed National Commission on Correctional Health Care is a not-for-profit activity that has as its sole purpose the improvement of medical and health care in correctional institutions. Twenty-one nationally prominent medical, legal, and corrections organizations have joined in the unprecedented action to solve the problems of inadequate

health care in the nation's jails, prisons, and juvenile detention facilities.

The AMA joined the American Bar Association, the American Nurses Association, and eighteen other major organizations in naming individuals to the board of directors of the commission.

"Thirty-nine states have prisons now under class action suits alleging inadequate medical services for prisoners and 35 percent of all jails have similar actions pending or are under court order," said Bernard P. Harrison, JD, president of the commission. "Regardless of how we feel about criminal justice issues, everyone agrees that prisoners have a constitutional right to adequate medical and health care. The commission will work toward that goal — through training and education programs and the accrediting of institutions that meet its standards."

Regarding the AMA's involvement in corrections health care, B. Jaye Anno, PhD, vice-president of the AMA's management program in that field, said, "We know of not a single instance where a jail, accredited as meeting AMA standards, has been successfully sued for inadequate health care." □

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Helicopter Emergency Service Halves Mortality Rates

Helicopter transport of accident victims to hospitals can reduce patient mortality rates to less than half of those reported when similarly injured patients are transported by land, according to a University of California Medical Center, San Diego, study. There researchers combined a unique control model and statistical technique to compare incidence of mortality among 150 helicopter-transported patients to the rate for 150 land-transported patients with similar injuries. They found that the airlifted patients experienced 52 percent less mortality. The researchers attribute this reduction to the expertly trained physician-nurse teams assigned to the helicopters and to the rapid transport time to the hospital after the patient was picked up.

This suggests that "not only was survival more likely in aeromedical patients in the more severe injury classifications, but that the aeromedical patients in those classifications who died were dying of more severe injuries than the nonsurvivors in the land group," say William G. Baxt, MD, and Peggy Moody, RN.

Although trauma remains the third leading

cause of death and the number one cause of death between ages 1 and 35 years, emergency care planners have remained skeptical about implementing the expensive air programs because previous reports did not seem to support the use of helicopter transportation.

"The equipment and personnel that are delivered by the helicopter and accompany the patient back to the hospital are clearly essential elements in improving patient outcome," says Howard R. Champion, FRCS, of Washington, (DC) Hospital Center, in an editorial in a recent *Journal of the American Medical Association (JAMA)*. "Unless the continuum of care is guaranteed at the receiving institution, the use of the helicopter is likely to be worthless in terms of patient outcome," he adds.

A helicopter is not inherently better than ground transport, Champion says. "It must be used with effective triage guidelines, a regional trauma center with committed physicians and nurses providing the highest level of care, and in concert with cooperative ground-based emergency medical systems. . . . The study by Baxt and Moody has shown with valid statistical underpinnings that helicopters can be of value in helping get the right patient to the right hospital in the right time — to save life." □



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Deaths

JOHN R. REID, JR, MD
1927 - 1983

Nowata general practitioner John R. Reid, Jr, MD, died June 14 in Nowata. Dr Reid, 55, was born in Altus. He graduated from the University of Oklahoma College of Medicine in 1956. A World War II army veteran, he moved to Nowata in 1959, where he served as chief of Surgery and Staff at Nowata General Hospital.

GILBERT E. HASLAM, JR, MD
1936 - 1983

Gilbert E. Haslam, Jr, MD, died June 15 in Tulsa. A Tulsa pediatrician, Haslam was born in Gadsden, Alabama, and graduated from the University of Oklahoma College of Medicine in 1962. He served in the US Army Medical Corps from 1966 to 1968.

THOMAS A. TROW, MD
1918 - 1983

Thomas A. Trow, MD, of Holdenville, died June 23. Dr Trow was born in Coalgate and graduated from the University of Oklahoma College of Medicine in 1942. He established his general practice in Okemah after three years' service in the US Air Corps Medical Department and later moved to Holdenville.

RICHARD D. MULLETT, MD
1932 - 1983

Richard D. Mullett, MD, Oklahoma City anesthesiologist, died June 28. Dr Mullett practiced in McAllen, Texas, for six years before moving to Oklahoma. Born in Akron, Ohio, he was a 1958 graduate of the Baylor University College of Medicine and a member of the American Society of Anesthesiology.

Oklahoma native Michael C. Manning, MD, of Moore, died July 3, 1983. Dr Manning was born in Wynnewood and studied medicine at the University of Oklahoma College of Medicine, where he graduated in 1974. A general surgeon, he established his practice in Moore in 1979.

In Memoriam

1982

<i>Thomas H. Fair, MD</i>	<i>August 15</i>
<i>Clyde E. Harris, MD</i>	<i>September 1</i>
<i>Tillman A. Ragan, MD</i>	<i>September 5</i>
<i>Floyd T. Hubbard, MD</i>	<i>September 23</i>
<i>William A. Eastland, MD</i>	<i>October 3</i>
<i>William J. Craig, MD</i>	<i>October 19</i>
<i>William M. Wood, MD</i>	<i>October 30</i>
<i>Hugh C. Graham, Sr, MD</i>	<i>November 11</i>
<i>John David Wilson, MD</i>	<i>November 11</i>
<i>Clinton Gallaher, MD</i>	<i>November 15</i>
<i>Bert F. Keltz, MD</i>	<i>November 30</i>
<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

<i>Dewey K. Rhea, MD</i>	<i>January 3</i>
<i>Fred C. Buffington, MD</i>	<i>January 4</i>
<i>C. D. Cunningham, MD</i>	<i>January 26</i>
<i>William S. Jacobs, MD</i>	<i>February 9</i>
<i>John R. Little, MD</i>	<i>February 11</i>
<i>L. A. S. Johnston, MD</i>	<i>February 16</i>
<i>Selwyn A. Willis, MD</i>	<i>March 3</i>
<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
<i>George M. Adams, MD</i>	<i>May 3</i>
<i>John R. Reid, Jr, MD</i>	<i>June 14</i>
<i>Gilbert E. Haslam, Jr, MD</i>	<i>June 15</i>
<i>Thomas A. Trow, MD</i>	<i>June 23</i>
<i>Richard D. Mullett, MD</i>	<i>June 28</i>
<i>Michael C. Manning, MD</i>	<i>July 3</i>

Significant Improvement in Fitness Noted in Tulsa Program

Significant improvements in cardiovascular endurance and abdominal strength were two of the many notable aftereffects of a fitness program piloted in the Tulsa Public Schools this past year. A sampling of over 7,000 boys and girls, ages 10 to 18, who participated in the testing process (pre-test in fall 1982 and post-test in spring 1983) received their individual test results in a FITNESSGRAM — designed to show how a student ranks against national norms on each item; an overall fitness score; cumulative growth records; and an "exercise prescription" recommending activities in those areas where the individual fell below the national norm.

The FITNESSGRAM, developed by the Institute for Aerobics Research, is presented by the President's Council on Physical Fitness and Sports, with Dr Don Cooper of Stillwater serving as a consultant. The FITNESSGRAM is receiving national support from the American Medical Association (AMA) and the National School Boards Association, among others. The American Alliance for Health and Physical Education is cooperating with the President's Council in presenting the program.

Improvement in the level of fitness was noted in every component measured but particularly in the areas of cardiovascular endurance and abdominal strength — those areas where American school children lag far behind their European and Asian counterparts.

The FITNESSGRAM, co-sponsored by the Oklahoma State Department of Education, will be initiated in 174 of the state's public and private school districts in the coming school year and will involve 180,000 boys and girls. It is scheduled for national implementation in 1984-1985. □

Surveys Show Public Opinion on Federal Regulation of Medicine

The American Medical Association (AMA) recently released the results of three separate public opinion polls related to regulation and the jurisdiction of the Federal Trade Commission (FTC) over medicine.

The studies indicated that between November 1982 and March 1983, public pref-

erence for a local rather than a national approach to the regulation of medicine increased significantly, becoming the majority viewpoint. The change was attributed to those who had no opinion in November deciding in favor of local regulation by March. However, when no option to federal regulation is presented, it continues to be favored by the public.

The polls also showed that between 1981 and 1983, the public image of the AMA rose two points, with 72 percent of those surveyed indicating either a great deal or a fair amount of confidence in the Association's ability to propose fair and workable health policies. Public confidence in other groups mentioned, such as the federal government, congressional committees, and labor unions, declined. Strong support was voiced for a continuation of activities of local medical organizations that have been called into question by recent FTC rulings. Among these activities was reviewing complaints of high fees, setting standards of quality and education, and developing broad programs to help control costs. □

AMA Council Calls For Passive Restraints in Autos

The American Medical Association (AMA) recently reaffirmed its support for the "development of effective passive crash protective systems for occupants of motor vehicles" in an AMA Council on Scientific Affairs report.

This recommendation conflicts with the National Highway Transportation Safety Agency's 1982 cancellation of passive restraint requirements for 1984 and later model cars. Passive restraint devices provide automatic protection without auto users taking any action.

The council also recommends that the AMA "encourage motor vehicle manufacturers to develop automobiles with stronger passenger compartments that would more effectively protect occupants, with interiors having fewer protruberant objects and hard surfaces that could cause injuries in crashes, and with fire- and explosion-resistant fuel tanks."

Legislators should also strengthen "drunk driving laws" and devote more resources to research that focuses on vehicle-related injuries and their prevention, the council says.

"Slowly, evidence is accumulating that behavioral factors other than the use of alcohol

play a role in crashes," the report states. "An opinion of several investigators who have made important contributions in the field of motor vehicle injuries is that 'a person drives as he or she lives,' " suggesting that erratic personal behavior may be translated into reckless driving.

In addition, the AMA council recommends establishment of a national goal of reducing motor-vehicle-related injuries, which account for 50,000 deaths annually. Such trauma is the leading cause of death in persons from one to 35 years of age. □

Book Reviews

Handbook of Behavioral Pediatrics. By Robert W. Black and Francis C. Rash. Chicago: Year Book Medical Publishers, Inc, 1981. Pp. 231. Price not given.

Drs Black and Rash have made a significant contribution to medical literature and the practice of pediatrics. The handbook is well indexed and the subject matter is divided into 208 sections or chapter headings. As the authors state, the handbook is not intended to be a complete discussion of all behavioral issues. It is a readily available resource for a quick reference to developmental problems encountered by students, residents, and practitioners of pediatrics. For the physician who desires a more exhaustive reference to specific behavioral problems, the handbook provides an excellent bibliography of reference material following each chapter heading.

The subject matter addressed in the handbook ranges from accidents and the prevention of accidents to stuttering, toilet training, and school failure. The authors have successfully put together in one compendium the major issues addressed in developmental or behavioral pediatrics. The book gives ready answers to parents' commonly asked questions regarding child behavior. The authors are obviously experienced pediatricians who have been repeatedly confronted by the situations and questions of frustrated anxious parents. The advice given by the authors about issues such as temper tantrums,* school phobias, thumb

sucking, and teething is based not only on scientific principles, but also clinical experience in dealing with childhood behavior. While many areas of the handbook deserve accolades, the chapters on sleep are particularly well written and provide useful information in a quick reference-type format. The authors are to be congratulated for the preparation of a needed and useful handbook.

Armond H. Start, MD, MPH
3400 North Eastern
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The Ambidextrous Historian. Historical Writers and Writing in the American West. By C.L. Sonnichsen. Norman: University of Oklahoma Press, 1981, pp. 120, \$9.95.

This small book contains a series of essays by C.L. Sonnichsen, senior editor of the *Journal of Arizona History* and emeritus professor of English at the University of Texas at El Paso. The essays are addressed to the "ambidextrous" historians of the American West — those who have a background in some other subject in addition to their historical specialty. Sonnichsen points out the contributions that can be made by the "grass roots historian," the history buff, or the high school English teacher; he encourages them in their pursuits but also points out the problems they may encounter. Sonnichsen argues that for the amateur there is excitement and poetry in exploring the past — a feeling that the professional historian not infrequently loses. He emphasizes that any background of experience can be useful to a collector of historical facts and that the best historians often get into the field as specialists in some entirely different discipline.

The author's thinking provides helpful guidance as well as understanding of the steps in conducting research, preparing a manuscript, and having it published. He underlines the importance of regional history, which may come from county courthouses, local libraries, state archives, and old newspaper files. He offers recommendations on research in these sources.

Aspiring "amateur" historians will benefit from Sonnichsen's expressions of his experience and his opinions.

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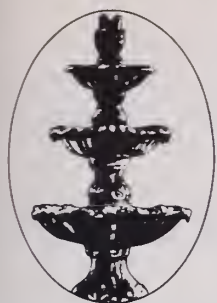
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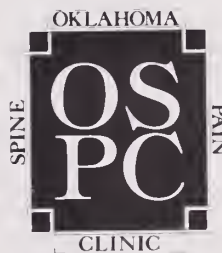
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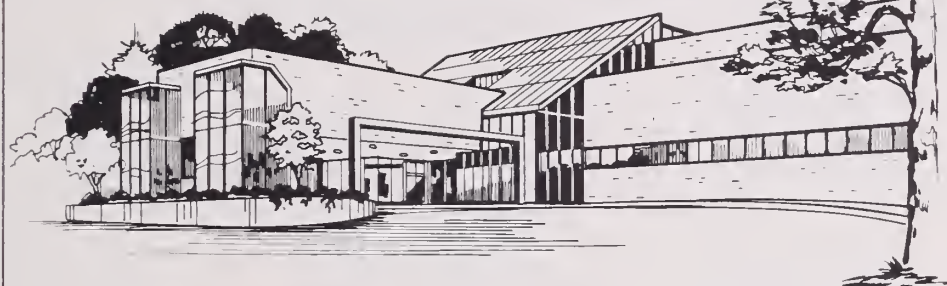
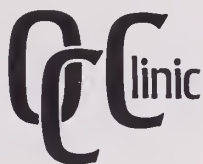
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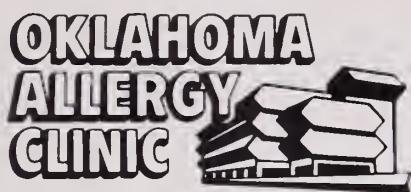
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The JOURNAL

of the Oklahoma State Medical Association

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STYLE

Footnotes, bibliographies, and legends for illustrations should be submitted on separate sheets, double-spaced. Bibliographies should follow in order of: name and author, title or article, name of periodical with volume number, page and date of publication. These references should be numbered in the sequence in which they appear in the article.

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NEWS

Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

ADVERTISING

All advertising copy must be approved by the Editorial Board before acceptance for publication. General and miscellaneous advertising rates will be sent on request.

EDITING SERVICE

The Editorial Board reserves the prerogative to submit contributions to a Medical Editing Service when warranted. If such is felt necessary, the Editor will contact the author for approval, informing him that there will be a modest charge for this service.

REPRINTS

Authors will receive reprint order forms from the Transcript Press, PO Drawer 1058, Norman, Oklahoma 73070, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

OKLAHOMA STATE MEDICAL ASSOCIATION

Confluence '83

For the first time, the Oklahoma State Medical Association Auxiliary will expand its fall Executive Board-Workshop meeting to a challenging two-day confluence. This confluence will be held at the Park Suite Hotel in Oklahoma City on September 26th and 27th.



Our keynote speaker will be Marsha Manatt Schuchard, PhD, author of *Parents, Peers, and Pot*. This book has been one of the most requested publications ever published by the National Institute of Drug Abuse and has been used by thousands of parents around the country both to deal with the drug problems within their own families and to organize their neighborhoods and communities.

In 1978, Dr Schuchard, together with Dr Thomas Gleaton of Georgia State University, opened the Parent Resource Institute for Drug Education (PRIDE), which has provided information and help for parents and parent groups nationwide. She has appeared on numerous television shows such as the "McNeil/Lehrer Report," the "Today" show, and many local talk shows. In addition, she provided background research information for the "Good Morning, America" series on children and drugs, and for the NBC documentary "Reading, Writing and Reefers." She is currently working on a new book for the National Institute on Drug Abuse, which will be a sequel to *Parents, Peers, and Pot*.

We invite *all* interested persons to attend.

—Camille Harrison, President

The American Medical Women's Association will hold its first Midwest Regional Conference in Kansas City, Missouri, September 30 and October 1 and 2, 1983. The conference, to be held at the Hyatt Regency Hotel in Crown Center, is titled "Women in Medicine: Looking Ahead Today," and is directed toward all physicians, residents, fellows, and medical students. Those wishing to attend should write to the Office of Continuing Education, University of Kansas College of Health Sciences and Hospital, Rainbow at Olathe Boulevard, Kansas City, Kansas 66103, or call (913) 588-4488.

The American College of Utilization Review Physicians (ACURP) will host its tenth anniversary seminar, "Reorganization of Health Care: Reimbursement, Review, Processing," at the Fairmont Hotel in Denver, October 22 and 23, 1983. Among the topics to be discussed are medical cost control, hospital reimbursement, economic trends as they impinge on practicing physicians, and third party review without physician input. Registration information can be obtained by writing ACURP, 1108 North Second Street, Harrisburg, Pennsylvania 17102.

A group of more than 40 retired physicians in Oklahoma County recently organized the Retired Doctors Club. Newly elected officers are Hervey A. Foerster, MD, president; Waymon Thompson, MD, first vice-president; Charles O'Leary, MD, second vice-president; James Snow, MD, secretary-treasurer; and Ralph Smith, MD, historian. The doctors meet once a month for lunch at Baptist Hospital and all retired physicians are welcome to attend.

The American Medical Association (AMA) is the most influential organization in the health policy arena, according to a two-year study by the University of Chicago Sociology Department. Ninety percent of the leaders in 135 health care organizations, public and private, told interviewers that the AMA ranked higher than the US Department of Health and

Human Services and ahead of any of the health-related committees of Congress. The American Hospital Association ranked eighth, followed by the AFL-CIO (13th), Blue Cross/Blue Shield (14th), Association of American Medical Colleges (31st), and American Public Health Association and National Academy of Sciences/Institute of Medicine (tied for 44th).

The Allergy Clinic of Tulsa has been selected by the American Academy of Allergy to participate in a project for standardization of reporting stations for pollen and mold counts in the United States. Dr Leon Horowitz and Dr David S. Hurewitz, partners in the clinic, will join the nationwide project designed to develop systematic reporting that can be comparable from one part of the country to another. They and other participants will report their counts on a daily basis through December 1983.

Aetna Life and Casualty has moved its Medicare Claim Administration office in Oklahoma City, according to Fred C. Bush, Jr, manager. Physicians should note the new address, 701 Northwest 63rd Street, Oklahoma City, OK 73116. The phone number 848-7711, remains unchanged.

A new inactivated rabies vaccine has been tested successfully by Byron S. Berlin, MD, and colleagues at the Michigan Department of Public Health. The rhesus diploid-cell-strain vaccine, tested on 60 volunteers, offers clinicians and public health agencies a vaccine prepared from an alternate tissue source that is less likely to cause serious reactions than vaccines currently available.

The inflation rate for physicians' services slowed to 7.5% last year, a significant decrease from the 1981 rate of 11.7%. Despite the decrease, however, physicians' services outpaced the overall Consumer Price Index, which rose 3.9% in 1982. □

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sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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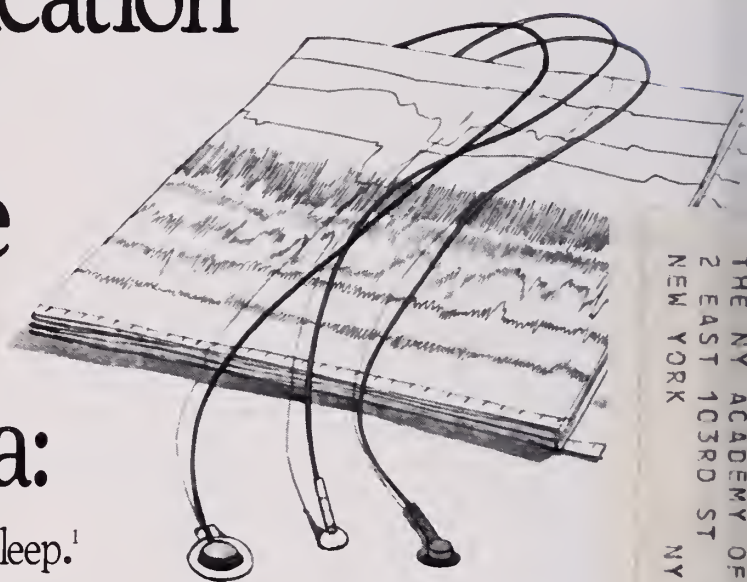
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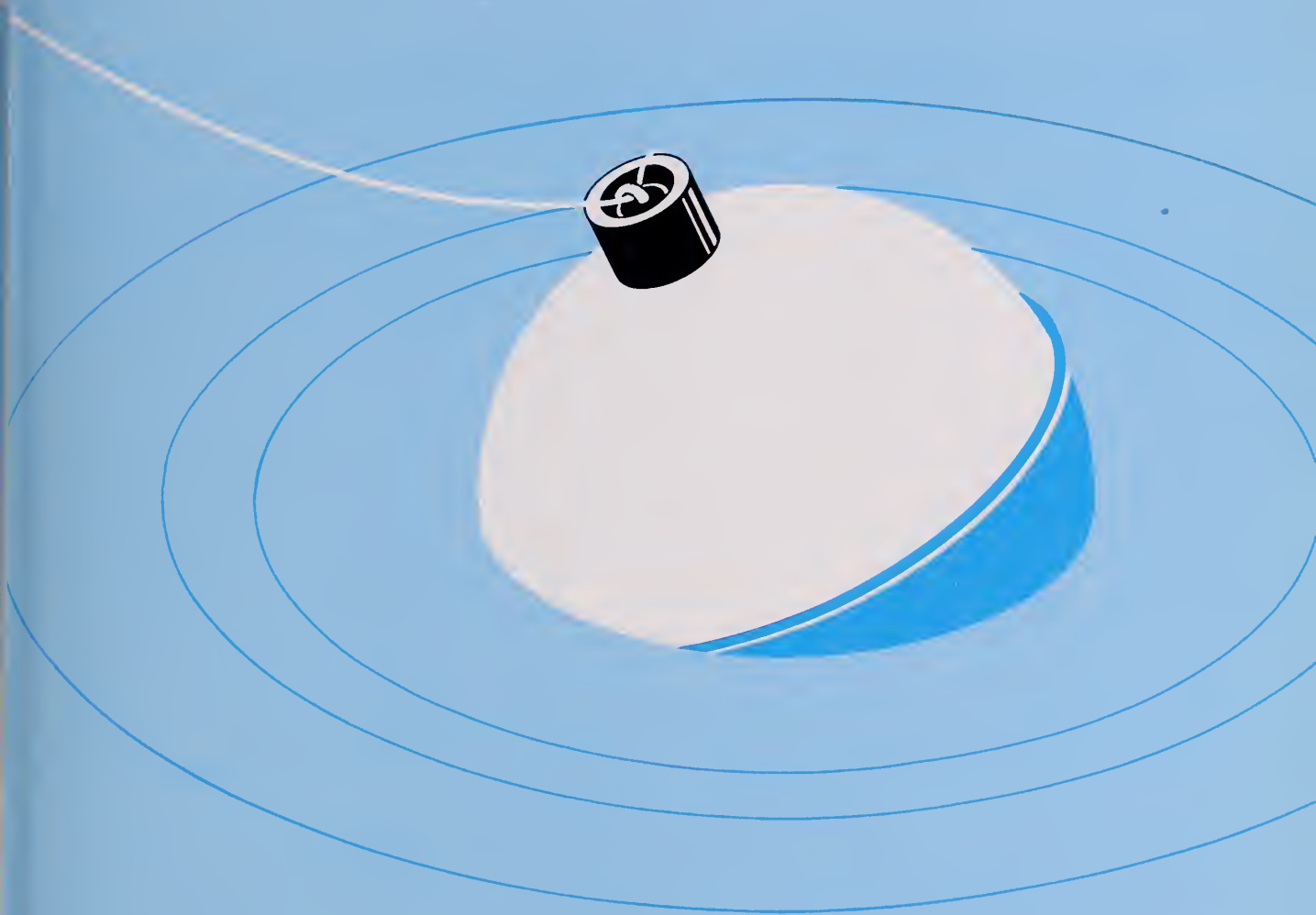


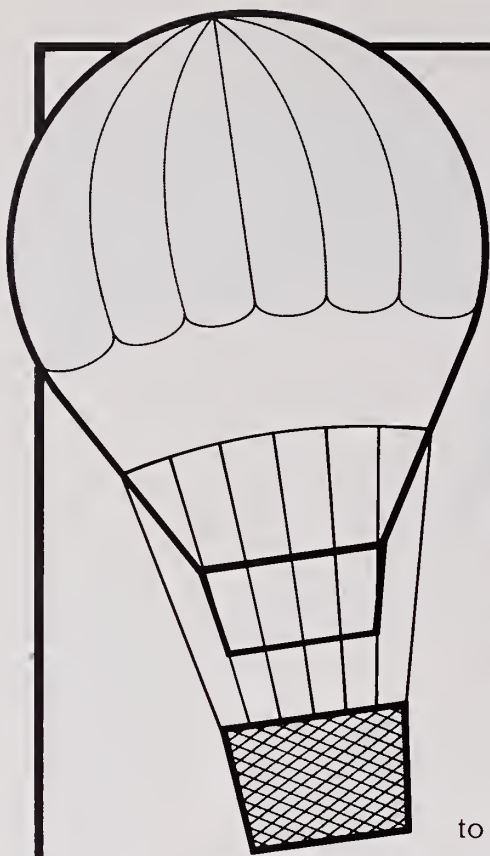
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



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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma. may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer IV slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (IV route preferred), 5 to 10 mg adult dose administered slowly; repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (IV preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow IV preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if IV cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg IV within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, IV fluids, adequate airway. Use levorotatory or metaraminol for hypotension. Dialysis is of limited value.

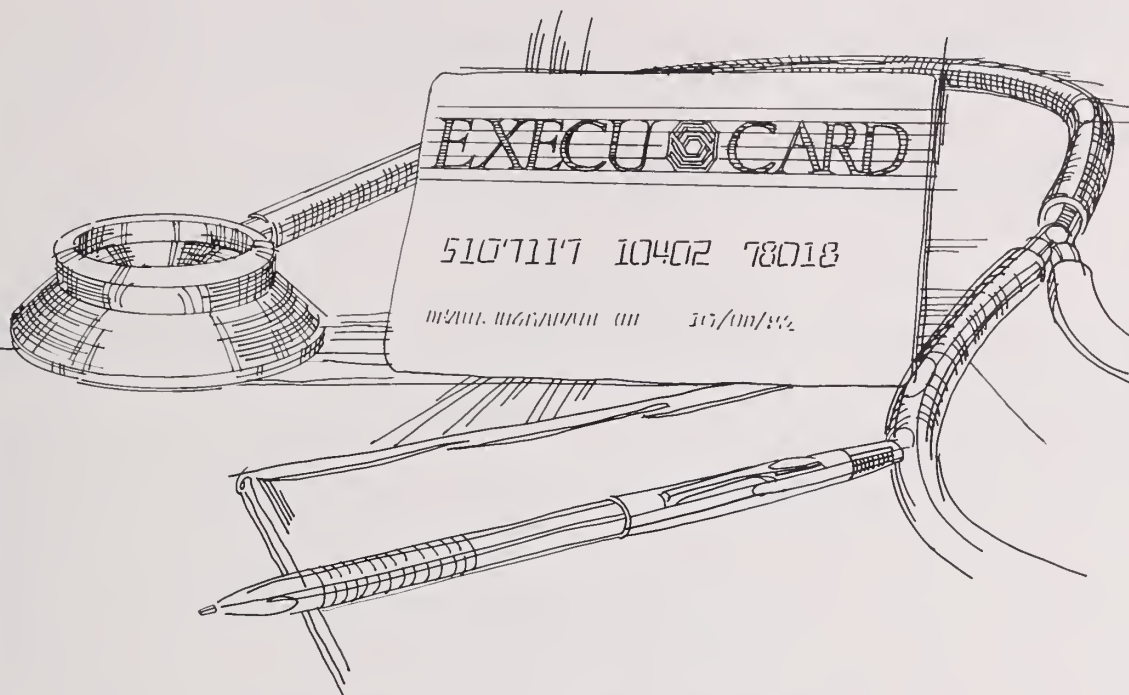
How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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Self Examination

If you get out of bed each morning looking forward to seeing your patients

If your patients ask you how *you* feel and inquire about your family

If you have made real friends of all your patients

If you feel flattered each time a new patient consults you

If you can imagine yourself in your patient's place and would willingly submit to and pay for all the tests and treatments you recommend

If you can say "I don't know" without a sense of shame

If you can welcome a request for another opinion

If you are proud of the clinical records you keep

If you can discuss and explain your fees without hesitation or hostility

If those who know you best become your patients

If you feel tears in your eyes when a patient dies but no guilt when you announce the death to the family

If those who help you care for your patients decline offers for more lucrative positions in order to continue caring for your patients

If you feel wealthy irrespective of the net worth shown on your financial statement

If the members of your family do not resent or sacrifice the time you spend with your patients

If your children visit with you during breakfast and dinner

If your family is bound in mutual respect, affection, and pleasure

If you are awed by the marvelous magic of the human body

If you are humbled by the majesty of the human mind

If your soul is nurtured by feeling needed

If your self esteem derives from serving others

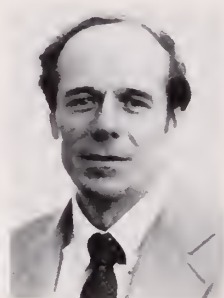
If you lie down at night filled with gratitude for the bounty of your life

Then you will know that you practice medicine not for a living but as a way of life. You will know that you *are* a physician.

Unfortunately you will also know that you are part of an endangered species.

-MRJ

Everyone likes to be associated with successful efforts, whether personal or professional. Certainly, the Physicians Liability Insurance Company, known to all of us as PLICO, is an outstanding success by any measurement. The board members of PLICO are all active, practicing physician members of the Oklahoma State Medical Association who spend a major part of one week-end every other month in Oklahoma City working on behalf of all of our physician members.



Now in its fourth year of operation, PLICO is an established leader nationally, of which we can all be proud. Under the leadership of President C. Alton Brown, MD, and the able guidance of the PLICO Board, both the professional liability insurance and the health and accident insurance programs have developed outstanding records. None of this would have been possible, of course, without the excellent management provided by the C. L. Frates company and Mr Rod Frates in particular. We should keep in mind that our management costs are 12% of premium income, approximately half the level of other carriers as reported by Bests Insurance Guide.

Although the PLICO Board was obviously concerned at their July meeting with the information that claims in May and June of 1983

were the greatest in number of any 60-day period in the operation of the company, PLICO has a long and successful record of claims management, underwriting, and loss prevention. This threatening situation will be followed very closely and all possible appropriate action taken.

PLICO Health, led by Dr Eugene G. Feild, has found it necessary to take several actions in order to operate with the original philosophy of being a financially self-sufficient program. Details of these changes in premium structure and terms will be reported separately to all of PLICO's insureds.

It should be kept firmly in mind, however, that these changes are such that PLICO Health premiums remain well below those of competing commercial carriers and the company operates with a very low overhead. The willingness of the C. L. Frates firm to freeze its management costs at the lower premium rate until PLICO Health is breaking even is further evidence of the excellent cooperation from our management company.

Again, the record is of a successful company, well managed and directed, which benefits Oklahoma physicians, their employees, and their families. We can be rightfully proud of PLICO and of the physicians and staff who make it a success story.

Eugene G. Feild, M.D.

Epidemic Histoplasmosis

HARRIS D. RILEY, JR, MD

Histoplasmosis not infrequently occurs in epidemic form. The epidemiologic, clinical, and other aspects of such epidemics in this country are analyzed. Preventive measures are reviewed.

Histoplasmosis was first described by Darling¹ in 1906. For many years after the first description, it was considered a rare, predominantly tropical, almost invariably fatal systemic infection.² However, in 1945 Christie and Peterson³ made the all-important observation of the existence of subclinical and benign infections and that their occurrence was extremely frequent. These findings were soon corroborated by the work of Palmer.⁴ In areas of the Mississippi River Valley, as high as 90% of the population exhibits sensitivity to histoplasmin as evidenced by positive histoplasmin skin tests by the age of 20.⁵ In the United States it is estimated that as many as 500,000 new infections occur each year.⁶

Surveys throughout the world have revealed areas of high prevalence in Asia, Europe, and South America.² In the great majority of cases, infection is symptomatic and benign. On the other hand the infection has a wide spectrum of severity which includes acute disseminated disease frequently fatal and chronic forms. Infection results in the great majority of instances from inhalation of spores of the fungus *Histoplasma capsulatum* which exists in a saprophytic state throughout much of the world. The ecology of the fungus has been extensively studied since it was first isolated from the soil in 1948 by Emmons.⁷ It is most frequently recovered from soils enriched by fecal excreta of birds, particularly starlings and chickens, and bats. This association with bird droppings may occur in restricted locations within endemic

***H capsulatum* is endemic to some extent in at least 31 of the 48 contiguous states.**

areas, such as roosting sites, or within selected closed environments (caves) and areas otherwise lacking suitable conditions for abundant growth of the fungus.^{2,5} *H capsulatum* is endemic to some extent in at least 31 of the 48

contiguous states.^{7a} Direct culture of soil specimens has demonstrated that distribution of the organism is spotty rather than generalized, isolates being substantially more frequent in avian and bat habitats. The factors promoting growth of the fungus have been reviewed.^{7a}

Outbreaks of acute pulmonary histoplasmosis have often been described.⁸⁻¹² They have arisen in both endemic and non-endemic areas and many have been demonstrated to result from an identifiable exposure to dust, often contaminated by droppings containing the fungus. Some of the outbreaks constitute fascinating examples in medical epidemiology.

The first reported outbreak of acute pulmonary histoplasmosis occurred in 1938,¹³ but the knowledge that it was due to *H capsulatum* did not come until some ten years later.¹⁰ Among the earliest outbreaks was one which occurred in 1944 at Camp Gruber, Oklahoma.^{11,12} Since those early experiences, numerous outbreaks have been described and discussed.^{8,14,15} By 1957, 41 outbreaks* occurring in 17 states involving more than 400 persons were known.¹⁴ At least 60 outbreaks had been described by 1981. Studies of these outbreaks have firmly established the clinical manifestations of acute pulmonary histoplasmosis and the association of the fungus with avian habitats—chicken houses, blackbird and pigeon roosts, and bat-occupied caves.^{7a} Study of these outbreaks suggests that *H capsulatum*, although worldwide in distribution, produces the large concentration of spores required to cause epidemic disease only in certain moist and heavily fertilized "microfoci."¹⁶

Large epidemics of acute pulmonary histoplasmosis are not unusual. Sixteen of the reported outbreaks involved ten or more symptomatic cases. These occurred in 11 states between 1938 and 1980.¹⁷ There is no particular seasonal trend, and clinical attack rates have varied from 10% to 100%.¹⁷ The severity of clinical disease probably related to host factors. Previous infection with the fungus confers a degree of protection but does not always prevent reinfection following heavy exposure.¹⁷

Several particularly interesting and instructive outbreaks have recently been described. One took place within Williamson County,

Tennessee — an area long known to be endemic.¹⁸ In this outbreak 42 persons accompanied by five dogs had gathered over a weekend to section and clear an oak tree which had been felled in a storm. Subsequently acute pulmonary disease developed in 20 of the participants, as well as in two of the dogs; in three human infections it was severe enough to warrant admission to the hospital. Serological evidence of infection was found in an additional 12 who were either asymptomatic or not ill enough to qualify as definitive cases. In those who became ill, the diagnosis was based on clinical features of pneumonia consistent with, but not exclusive to, histoplasmosis coupled with epidemiological evidence of a common-source infection; serological confirmation was obtained subsequently.² In endemic areas the persistence of low antibody levels in a proportion of the population may complicate the interpretation of serological tests; the investigators in this study included controlled sera from people not present at the tree-cutting.

Studies of these outbreaks have firmly established the clinical manifestations of acute pulmonary histoplasmosis and the association of the fungus with avian habitats . . .

The immunodiffusion tests proved to be the most useful for diagnosing infection when sera was obtained one to two weeks after the onset of illness.² At this incident those engaged in sawing and loading wood debris had significantly greater risk of becoming ill than those present only in a passive role.²

In contrast to this small-scale outbreak within an area of known high endemicity, there are now accounts of a much larger outbreak in Indianapolis, Indiana.^{19,20} The outbreak took place between September 1978 and August 1979. An estimated 120,000 residents of Indianapolis were infected. The outbreak resulted in at least 488 clinically recognized cases. Nineteen patients died and 55 had progressive disseminated infections. At least 24 patients had pericarditis, 26 rheumatologic syndromes, and 18 unusual manifestations of the infection. Patients of all ages — from infants to the elderly — were affected, but 52% of the patients were between 15 and 34 years of

* Defined as two or more persons acquiring their infection at the same point source.

age and 63% were black. The highest attack rate was in the central portion of the city, which is a disproportionately black section. The source of the outbreak has not been proved by positive cultures. Two sites, however, were suspected on an epidemiologic basis. Immunosuppression was the strongest risk factor identified for disseminated or fatal infection. Circumstantial evidence suggests that the source was demolition activity at an abandoned amusement park, with widespread airborne

The outbreak was traced to a roost site which had been cleared of trees for several years, a finding with important public health implications.

dissemination of the fungus to a thickly populated area. To date, attempts to recover *H capsulatum* from soil samples at this and other sites under investigation have been unsuccessful.² It has been shown that 47% of teenagers attending schools within about ten kilometers of the park have serological evidence of infection compared with 17% from other high schools in the city.²

Another interesting outbreak from Tennessee has been reported recently. In August 1980, an outbreak of acute pulmonary histoplasmosis occurred among migrants who were participants in a wagon train as it traveled through eastern Tennessee. Of the 85 persons on the train, 69 (81%) exhibited evidence of infection with *H capsulatum*. Of these, 54 had symptomatic disease. Infection was confirmed by a four-fold rise in complement-fixing antibodies to *H capsulatum* yeast antigen or a positive skin test result. The source of infection was traced to the site of a former blackbird roost in a small southeastern Tennessee town that had been partially cleared five years earlier to establish a park. The wagon train had camped for one day in an adjacent field eight days before the onset of the outbreak. Fourteen of 25 soil samples from the wooded site of the roost yielded *H capsulatum*.²¹

This outbreak is unusual in several respects. It is the first reported outbreak to involve a large migrant group. Although sporadic cases and small family outbreaks of acute pulmonary histoplasmosis have been attributed to

apparently mild dust exposures, this is the first large outbreak in which no obvious disruption of infected soil or rotten wood occurred. Exposure occurred without excavation, construction, or tree-cutting at the site. Another important aspect is that the outbreak was traced to a roost site which had been cleared of trees for several years, a finding with important public health implications.

The sources of these outbreaks characterized by 10 or more symptomatic cases in the United States include all the common habits of *H capsulatum*, according to Gustafson et al.²¹ One outbreak was attributed to chicken manure, two to soil in bat-infested caves, three to the sawing of rotten wood, three to pigeon droppings in old buildings, and seven to the soil of blackbird roosts. These sources are also representative of smaller reported outbreaks, except that chicken houses figure more prominently in small family outbreaks.^{14,15} In every outbreak, digging, raking, or otherwise aerosolizing contaminated dust or manure was the activity leading to exposure. In most cases, only people within 10 to 20 feet of dust-raising activities acquired the disease. Indeed, in only five outbreaks did persons other than those actually performing the work become ill. In three of these five outbreaks, large populations were exposed when spores were aerosolized within a few feet of air-conditioning intake vents. In the other two outbreaks, disruption of the sites continued for several weeks, and the exact nature of exposure at these locations could not be determined.²¹

In every outbreak, digging, raking, or otherwise aerosolizing contaminated dust or manure was the activity leading to exposure.

The differential diagnosis of histoplasmosis from other acute respiratory infections may be difficult if not impossible from clinical and radiological features alone. These reports from Tennessee and Indiana illustrate several important points. They underline the value of cooperative studies by clinicians, epidemiologists, microbiologists, and mycologists in identifying and determining the extent of an outbreak.² They also emphasize the importance of education of persons who may come in

contact with possible microfoci of the need to take proper protective steps against exposure. A condition of this is the need to find and use proper treatment of known potential microfoci before they are disrupted. Microfoci containing *H capsulatum* spores are located not only in avian habitats and caves in rural areas but also in parks, open fields, and old buildings in many US cities which are frequently disturbed during construction and demolition activities.

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Nutritional Support For the Geriatric Surgical Patient

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Nutritional deficiencies in the elderly are often subtle, requiring careful assessment, specific replacement therapy combined with appropriate route of administration, and careful monitoring.

Introduction

Techniques designed to provide preoperative and postoperative nutritional support have become helpful adjuncts, permitting aggressive surgical therapy with increased safety. The geriatric patient undergoing a major operative procedure frequently presents with special nutritional and metabolic problems, both diagnostically and therapeutically. Such nutritional deficiencies may result from poor dietary habits, chronic illnesses, malignant disease, or socioeconomic factors.¹ These deficiencies, often subtle, become clinically significant

in debilitating illnesses and major surgical procedures.²⁻⁵ Furthermore, if they go unrecognized, mortality and morbidity increase, and hospitalization is prolonged, with accompanying higher health care costs. These results are often glossed over with the facile statement, "There was so little to work with in this patient."

Accurate history-taking is often hampered by the patient's seemingly stoic attitude, poor communication, senility, or cerebral insufficiency. Elderly individuals who live alone often have poor eating habits accompanied by a low level of daily activity; they may easily slide into a low caloric intake state without being aware of it. Often, a review of their menus at nursing homes will be helpful in this assessment.

The goal of nutritional support is to provide sufficient calories and nitrogen to meet the patient's required metabolic, energy, and protein demands. This support may take the form of maintenance nutrition in elderly patients in an acceptable nutritional state, or such support may be geared toward restoring an acceptable nutritional state; in patients undergoing acute stress or a major operative procedure, accelerated calorie demand must be met. In each of

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these categories metabolic needs must be tailored to the specific presenting situation.

The success of nutritional support depends on (1) accurate assessment of the patient's current status, (2) determination of the reason for the state of poor nutrition, (3) estimation and provision of adequate calories, proteins, and electrolytes, and (4) elimination of the root cause(s) of the poor nutritional status.

An initial evaluation of the patient's overall nutritional status provides important baseline information, and pertinent historical data, photographs, or both, if available, may provide some gross estimation of the depletion of lean body mass and fat stores. Additionally, a history of weight loss and a record of daily weights, when available, are helpful, and comparative arm muscle circumference and triceps skin fold measurements are clinically useful.⁶

The Importance of Nutritional Support

Postoperative hormonal response and feedback are such that body fat and protein are mobilized, and the anabolic processes are depressed by the antiinsulin effects of high circulating levels of both glucocorticoids and catecholamines. The mobilization of skeletal protein contributes both calories (via gluconeogenesis) and amino acids for the biosynthesis of vital proteins (ie, enzymes, coagulation factors, and structural proteins). Nitrogen losses during this catabolic phase may be less.⁷ The major energy-producing substrate is provided by fat mobilization, so the provision of unneeded, excess calories may worsen the catabolic state by increasing the visceral work load.⁷ Also, ingested or infused protein and

nonprotein substrates are metabolized by the liver, hence hepatic function is an important aspect of nutritional assessment. After the catabolic effects of acute stress subside, however, adequate amounts of protein and calories become even more important.

Selecting the Route of Administration

Nutritional support may be administered by the oral (gastrointestinal) or intravenous route or by a combination of both. The selection of a route of administration should reflect the anticipated duration of administration, availability of the gastrointestinal tract, cost, possible complications of each route of administration, and the surgeon's familiarity with the specific route. *The state of the gastrointestinal tract is the single most important factor in determining the optimal route for nutritional support.* If an unobstructed functional segment of the gastrointestinal tract is available, this route is more efficient, less costly, and carries less risk than parenteral methods. However, the presence of peritonitis, malabsorption, obstruction, high-output fistulas, or an inability to tolerate feedings would seriously militate against its use. When the gastrointestinal tract is not available, alternate methods must be skillfully substituted to provide the needed support, and if massive nutritional support is required, eg, in major burns, both the gastrointestinal tract and alternate routes (ie, tube feedings or intravenous methods) may be combined.

Establishing Gastrointestinal Access

Access to the gastrointestinal tract may be obtained by utilization of feeding tubes, ie, nasogastric tube, gastrostomy, pyriformostomy,

Table 1. Elemental Diets

	Calories per milliliter	Calories of protein (percent)	Calories of carbohydrate (percent)	Calories of fat (percent)	N:C ratio
Flexical [®]	1.00	8.8	61.1	30.10	1:264
Precision LR Diet [™]	1.08	8.8	90.8	0.65	1:258
Vivonex [®]	1.00	8.1	90.3	1.30	1:286
Precision High Nitrogen Diet [®]	1.00	16.6	82.9	0.42	1:125
Vivonex [®] HN	1.00	16.6	84.1	0.78	1:127
Amin-Aid [®]	1.02	4.0	68.0	28.00	1:418

cervical esophagostomy, or feeding jejunostomy. The major concerns of this approach are patient comfort, ease of administration, avoidance of potential aspiration, and the placement of tubes beyond the areas of obstruction or fistula. Nasogastric tubes are tolerated best when a small 8 to 10 French catheter with multiple perforations is used. Although a small tube is more comfortable and causes less nasopharyngeal irritation, it is difficult to continually administer feedings of thick consistency. Con-

Elderly individuals . . . may easily slide into a low caloric intake state without being aware of it.

sequently, a variety of tubes designed particularly for this purpose are currently available. Radiographic confirmation of the placement of the nasogastric and other feeding tubes is essential to avoid the tubes' being curled upon themselves in the stomach and to minimize reflux. Transcutaneous intubation of the gastrointestinal tract allows the placement of larger tubes for longer periods of time with improved patient comfort. Potential complications of nasogastric feedings are nausea, vomiting, diarrhea, gastric retention, aspiration, and otitis media.

Pyriformostomy and cervicoesophagostomy should be considered in the presence of head and neck tumors, oral pathology, trauma, or irreversible neurologic conditions, and lesions of the esophagus may require distal gastrotomy. The techniques of carrying out these procedures are numerous and have been adequately described elsewhere.⁸⁻¹⁰ Proximal

small-bowel obstruction and fistulas may be best handled with a distally placed feeding jejunostomy. These feedings may be administered by intermittent bolus or by continuous drip; the manner in which they are given will depend on the location of the tube, the type and concentration of the formula, and patient tolerance. Feedings should be initiated slowly in the elderly patient and increased gradually because most nutritional supplements are hyperosmolar and if given too rapidly will induce nausea, vomiting, abdominal cramps, and diarrhea; most of these feedings are best tolerated if initially diluted and given as isosmotic fluids. The concentration and volume should not be increased simultaneously. Hyperosmolar dehydration and azotemia can result from high osmolar loads, particularly when liver or renal function is abnormal, so the necessity for daily monitoring of weight, fluids and electrolytes, and renal and hepatic function cannot be overemphasized.

Specific Oral Feedings

A variety of constantly improving commercial caloric sources is available for oral use. Generally, they are divided into two groups, those that require digestion and those that do not (Elemental Diets, Table 1). The nutritional supplements and meal replacements differ widely in composition (Table 2), require digestion, generally contain approximately one calorie per milliliter, and most contain lactose. This is significant in that lactose intolerance is not uncommon in geriatric patients.

A review of the preparations currently available reveals that their fat content may also become a problem, as fat digestion is impaired in many disease states of the aged. In most short-term situations, fat needs can be

Table 2. Nutritional Supplements and Meal Replacements (Oral or Tube Feedings)

	Calories per milliliter	Calories of protein (percent)	Calories of carbohydrate (percent)	Calories of fat (percent)	N:C ratio
Citrotein®	0.53	24.1	73.2	2.3	1:93
Meritene®	1.00	24.0	46.0	30.0	1:79
Sustacal®	1.00	24.0	41.3	20.7	1:79
Compleat-B®	1.00	16.0	48.0	36.0	1:131
Ensure®*	1.06	14.0	54.5	31.5	1:155
Isocal®**	1.05	12.9	49.6	38.5	1:169
Portagen®***	1.00	16.0	44.0	40.0	1:160

* Lactose-free ** Isosmolar *** For fat malabsorption

met from endogenous stores, or small amounts of supplemental lipid can be used to prevent fatty acid deficiency. Medium-chain triglycerides also are useful in cases of fat intolerance because they do not depend on micelle formation, are rapidly absorbed and transferred to the liver without alteration, and are more rapidly metabolized than long-chain triglycerides.

The nutritional supplements mentioned are essentially protein supplements and contain nitrogen: calorie (N:C) ratios far in excess of that recommended for anabolic activity,⁷ while the meal replacements more closely approximate anabolism N:C ratios. These two groups often are used to supplement inadequate oral intake or to provide total intake for long-term management in patients with intact intestinal tracts. Hospital-prepared blenderized food may serve the same function at considerably less cost. In this regard, much is to be gained from active communication and cooperation with nutritional therapists. As maintenance diets, meal replacements contain excess protein nitrogen, but they have considerable advantage in regard to patient tolerance because they contain whole proteins and are more palatable than elemental diets.

Elemental diets are compounded mixtures of L-amino acids, monosaccharides, disaccharides, hydrolyzed starch, and electrolytes. These diets may be particularly useful in patients 65 years of age or over who have inter-

dental wiring, acute diverticulitis, inflammatory bowel disease, carcinomatosis, short-bowel syndrome, biliary fistulas, radiation enteritis, or small-bowel fistulas, and in pre-operative bowel preparation.^{11,12} We have come to rely on these diets as a substitute for intravenous hyperalimentation. They are bulk-free and virtually fat-free, requiring minimal digestion. At full concentration, they contain about 1 calorie per ml, with an N:C ratio of

Intravenous hyperalimentation has proved to be of significant value in nutritional therapy.

1:304 to 1:125. Because of their composition, pancreatic and biliary secretions are not necessary for their absorption, and secretions from these two tracts decrease in volume, beginning on about the fourth or fifth day of their administration.¹³⁻¹⁵ The volume of fecal output is also markedly decreased. The chemical nature of these preparations demands close control by the surgeon of the caloric, electrolyte, and water intake in any patient, but especially in the elderly. Elemental diets are expensive, but they may help to avoid the potential complications of total parenteral nutrition.

The decreased palatability of elemental diets (due to a sweet, pasty taste that is attributed to the large amount of thiamine present) often makes tube feeding better than oral administration. Various flavors have recently been

Table 3. Protein Sources and Solution Preparation*

	Sodium	Potas- sium	Magne- sium	Phos- phate	Calcium	Chlo- ride	Acetate
Daily requirement (mEq)	60-80	80-120	8-16	30-45	9-18	—	—
Freamine 11® 8.5%	5	0	0	0	0	0	0
**Add mEq/liter	15-35	30-40	3-5	10-15	3-6		
Travasol® 5.5%	35	30	5	30	0	35	65
**Add mEq/liter	0	0-10	0-1	0	3-6		
Abbott amino acid 3.5%	20	9	1.5	0	0	20	8
**Add mEq/liter	0-10	18-31	1-3.8	10-15	3-6		
Aminosol® 5%	5	5	0	0	0	0	0
**Add mEq/liter	15-25	22-35	2.6-5.3	10-15	3-6		
Hyprotigen™ 10%	25	18	2	25	5	18	0
**Add mEq/liter	0-5	9-22	1-5	0-1			
Cutter hydrolysate 5%	19.5	9	0	0	0	0	0
**Add mEq/liter	0.8	18-31	3-5	10-15	3-6		

*Supplements:

Multivitamin infusion — 1 ampule per day

Vitamin B₁₂ — 1,000 ug per month

Vitamin K — 10 mg per week

Folic acid — 5 to 10 mg per week

**Based on a total of 3 liters per day of intravenous hyperalimentation.

added to these commercially prepared formulas to improve palatability.

Use of elemental diets does require a length of functional small bowel sufficient to permit the absorption of simple sugars and amino acids. While these diets cannot replace total parenteral alimentation in all situations, they are sufficiently versatile to have wide clinical application. In these conditions, it is possible to put the intestinal tract at rest, with a decrease in gastrointestinal secretions and stool volume, but still use it for the absorption of nutrients. If the length of bowel is extremely short or if the fistula is high with a large volume output, the elemental diet is best used in the adaptive phase.

Starting these diets too early may lead to an increase in diarrhea or fistula output. In such situations, intravenous hyperalimentation should be used until the bowel has adapted, at which time the elemental diet can be initiated.¹⁶ In severe, complicated pancreatitis, use of elemental diets has resulted in a marked decrease in pancreatic fistula output followed by closure. Similar results have been reported with fistulas of the biliary tract.¹⁵

Intravenous Hyperalimentation

Intravenous hyperalimentation has proved to be of significant value in nutritional therapy. This technique achieves net anabolism through the administration of a mixture of protein hydrolysate or crystalline amino acids with hypertonic glucose, electrolytes, and vitamins. Table 3 lists the commercially available preparations most widely used and the additive supplements required for optimal use of this technique. Protein hydrolysates are produced by the acid hydrolysis of fibrin or casein and as such contain amino acids, dipeptides, and tripeptides. Crystalline amino acids are better used than hydrolysates and cause fewer allergic reactions. These protein sources provide 6 to 8 gm of nitrogen per 1,000 calories, with an N:C ratio of 1:166 to 1:125. Intravenous hyperalimentation is accomplished by infusing the hyperosmolar solution into a centrally lying vein, usually the superior vena cava, with access percutaneously through the subclavian vein. This permits instantaneous mixing in a high-flow venous system, preventing venous thrombosis and allowing an even distribution of the solution in the circulatory system through which 1 to 5 liters can be administered each day.^{17,18}

Table 4. Complications of Intravenous Hyperalimentation

Catheter-Related	Infusion-Related
Hemothorax	Hyperglycemia, glycosuria
Pneumothorax	Hypokalemia
Arterial puncture	Fluid overload
Catheter emboli	Hypertonic dehydration
Air embolus	Hyperosmolar, nonketotic coma
Catheter sepsis	Essentially fatty acid deficiency
	Fatty metamorphosis of liver

The meticulous preparation of the base solution by the hospital pharmacy is of paramount importance. The amino acid solution is added to 50% glucose in water under a laminar flow hood. Electrolytes and a once-daily supplement of calcium and water-soluble and fat-soluble vitamins are added later. Composition of the base solution may be altered as indicated by clinical circumstances and daily requirements.

Of particular concern in using this nutritional technique in the elderly would be the onset of hyperosmolar nonketotic hyperglycemia. This phenomenon occurs with a too-rapid infusion of the hypertonic fluid, resulting in osmotic diuresis, dehydration, central nervous system irritability, and convulsions. The patient becomes weak, listless, and eventually comatose. Prompt treatment of this syndrome requires the judicious infusion of isotonic saline and/or glucose solutions with insulin while serially determining fluid balance, central venous pressure, serum electrolytes, and blood and urine sugars. This syndrome in the patient aged 65 years and over is prevented by close clinical observation and laboratory monitoring.

In patients with acute or chronic renal failure or with compromised hepatic function, uremia or hyperammonemia is a frequent accompaniment, placing particular constraints on nutritional management. Special solutions of hypertonic dextrose and the eight essential L-amino acids are added for the nutritional benefit of these patients.^{19,20} The provision of nitrogen-containing food by mouth or nitrogen-containing amino acids or protein hydrolysates by vein may further aggravate the condition, with resulting retention of metabolic waste products and without improving the patient's nutritional status. Many of

Table 5. Side Effects of Fat Emulsions

Minor	Major
Local skin irritation	Tachycardia, tachypnea
Liver enzyme elevation	Hepatosplenomegaly
Temperature elevation	Leukopenia, thrombocytopenia
Rash	Coagulation defects
	Nausea, vomiting, fever, chills
	Allergic reactions
	Irritability, lethargy

these patients cannot be given the usual amounts of water orally or parenterally because of anuria, oliguria, or excessive fluid retention. The use of the nitrogen from urea and ammonia has been demonstrated and is to the patient's nutritional and therapeutic benefit. In essence, this is a purified intravenous version of the oral Giordano-Giovanetti diet.

Newer preparations are available that contain amino acids precipitated as acetate and phosphate salts, obviating the problem of hyperchloremia. Potassium supplementation is important in the use of infused glucose; hence, approximately 40 mEq of potassium per 1,000 calories should be added in addition to replacement of the abnormal losses that might occur from gastrointestinal tract or biliary-pancreatic fistulas. Calcium and magnesium supplements also must be provided because of their crucial role in intermediary metabolism,

and other supplements that include vitamin B₁₂ (1,000 ug per month, folic acid (5 to 10 mg per week), and vitamin K (10 mg per week) should be added. Should any of the complications of intravenous hyperalimentation listed in Table 4 be encountered in managing the elderly patient, the end results could add a measurable amount of morbidity or even be fatal.

The popularity and success of intravenous hyperalimentation have led to a revived interest in fat emulsions (Intralipid® 10%).²¹ Soybean oil emulsion provides nonprotein calories safely and in an isotonic form that does not result in vein irritation; when given in combination with amino acids and low concentrations of glucose, overload can be avoided. Intralipid® is an iso-osmolar (280 mOsm) emulsion of soybean oil, phospholipids, glycerol, and water that provides a total of 1.1 calories per milliliter. The fatty acid content is sufficient to prevent the essential fatty acid deficiency occasionally observed with intravenous hyperalimentation. This infusion is supplied as a 10% emulsion, with recommended daily doses of 2.5 gm per kilogram of body weight per day in adults and 4 gm per kilogram per day in children, and may be administered centrally or peripherally. Fat emulsions are not generally used to provide 100% nonprotein calories in adults because in patients with a low body weight and high caloric requirement, the recommended doses may be exceeded, with resulting side effects. Untoward reactions (Table 5) have been observed, although they do not appear to be severe in most cases where soybean oil emulsions have been employed.

Table 6. Selection of Administration Route and Specific Agents

	Oral enteral supplement	Elemental diets	Intravenous hyperalimentation
Poor intake	xxx	xxx	xx
Small-bowel fistula	y	xx	xxx
Colon fistula	y	xxx	xxx
Short-bowel syndrome	x	xxx	xxx
Burns	xxx	xx	xx
Sepsis	xx	xx	xxx
Head and neck trauma/cancer	y	y	xxx
Esophageal obstruction	y	y	xxx
Pancreatitis	y	xx	xxx
Biliary fistula	y	xx	xxx
Inflammatory bowel	y	xx	xxx

xxx = preferred.

xx = acceptable.

x = least effective.

y = ineffective or contraindicated.

Summary

An appropriately designed program of nutritional support will allow the geriatric patient to undergo necessary surgical therapy with fewer risks and improved results. The selection of the route of administration and the specific nutritional replacement will depend on the functional status of the gastrointestinal tract and patient's protein and calorie requirements. Table 6 summarizes our recommendations in this selection process. Our obvious preference of routes is the gastrointestinal tract when it is available. When this optimum method of nutritional management is not available, sequential or concurrent supplemental feedings or intravenous hyperalimentation is indicated to achieve adequate protein-calorie intake. Regardless of the route chosen, careful monitoring of the geriatric patient's response to nutritional therapy is required. Only through careful planning and execution of nutritional therapy can optimum results be achieved in this group of patients.

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Diagnosis Related Groups: A New Way of Managing Hospital Revenues, Costs, Reimbursement

PETER J. LEVIN, ScD
JAMES F. SILVERMAN, MD
ROLAND S. MERCHANT, SR, MSHA

Medicare will now reimburse hospitals a fixed amount for care given to patients fitting into a particular DRG. Physicians may feel pressured under the new payment system.

Some people believe that the payment of hospital bills by third parties is a major reason for the increase in hospital costs. This is because government and other third parties responsible for making payments to hospitals have not had sufficient control or incentive to keep costs down.¹

There are several ways hospitals are paid. Usually, hospital revenues are linked to the length of stay of individual patients. For patients paid for by Medicare, Medicaid, and many Blue Cross plans, hospital reimbursement is based on the number of days of care provided to patients covered or insured by a particular program. The actual payment from the third party for a day of care is derived from the following process: accounting guidelines are laid down by each third party; the hospital

calculates a day rate (per diem) for each payer's patients; the hospital is paid this average rate with a year-end adjustment. Per diem payment has allowed one amount for routine services (room and board), and includes admitting, accounting, nursing, housekeeping, dietary, etc. Ancillary services such as laboratory tests, X-rays, operating rooms, and special treatments are billed separately.

There is a difference between the way private insurance companies and government payers cover hospital bills. Private insurance companies usually pay the hospital charges incurred by their policyholders, while government pays costs. Charges and costs are not the same. Charges are prices set by the hospital, while costs are calculated using a formula set by the third party. Therefore, hospitals receive revenues for routine inpatient care on two different bases; the first method is based on average cost per patient day for the beneficiaries of a particular third party payer, and the second on direct charges to individuals and insurance companies.

Because of the acknowledged inadequacies of the present system of paying for hospital care, researchers have tried to find alternative ways that would somehow stimulate a hospital to contain costs and yet provide the services necessary for treatment of the patient's illness. The intent behind this was to develop a mea-

surement of patient acuteness and the related use of hospital services so that hospital payment would be based on a patient's appropriate use of services rather than institutional costs.² In theory, care for patients with similar diagnoses should be paid for at similar rates, and resource utilization should be diagnosis related. There have been numerous attempts to achieve this, and researchers at Yale have developed a system based on diagnosis related groups (DRGs) that will be used as the payment basis for Medicare patients after October 1, 1983.

Utilizing length of stay as the dependent variable, similar diagnoses were grouped and refined so that patients were classified into medically meaningful categories with a relatively minor variation in the length of hospital stays. Originally, the International Classification of Diseases Adapted-8 (ICDA-8) diagnostic codes were collapsed into 83 major groups using the following criteria:

- Major diagnostic categories must have consistency in terms of their anatomical, physiopathological classification, or in the manner in which they are clinically managed;
- Major diagnostic categories must have a sufficient number of patients for a fair statistical base; and
- Major diagnostic categories must cover the complete range of codes without overlap.³

However, most of these groups were too broad to be useful for homogenous analysis of the length of stay. The Yale group then went through one million patient records using five independent variables (primary diagnosis, secondary diagnosis, age, primary treatment procedure, secondary treatment procedure). A computer program was used to subdivide the 83 major diagnostic groups. If a major diagnostic group turned out to be medically uninterpretable, had fewer than 100 cases, or had an unexplained variance that could not be reduced by one of the variables, it was not used. The result was 383 diagnosis related groups plus separate categories for deaths and for patients having extremely long lengths of stay. Further refinement for Medicare has resulted in 467 DRGs.

For example, a major diagnostic category, urinary calculus, was subdivided into four terminal DRGs on the basis of medical versus surgical treatment, type of surgery, and type of secondary diagnosis.⁴ The procedure was to array all patients in each group and eliminate

those with significantly longer or shorter stays than the majority. The tightest distribution of patients possible within each diagnosis related group is desired. Therefore, each group will have a small standard deviation and a low coefficient of variation showing a small relative dispersion of length of stay. It is then possible to compute the mean for a variety of hospital services provided to patients in each diagnosis related group. These diagnosis related groups are subject to further refinement based on experience.

This system obliges hospital management . . . to review the performance of physicians in the hospital based on productivity and profitability as defined by third-party payers.

Computrization makes it possible to relate an individual physician's care of patients to similar patients in the same department, same hospital, and same diagnosis related group in other institutions. The physician, therefore, becomes linked to the amount of money the hospital is paid for providing services to a patient in a particular diagnosis related group. The third-party payer will pay the hospital a set amount for a patient appearing within the distribution of patients in a diagnosis related group. In the distribution of patients within a group, there will be variations in the hospital services provided, and a hospital may lose money because of the particular treatment pattern for an individual patient or by an individual physician. Thus, an entirely new system emerges for viewing hospital productivity and, in particular, physician treatment and patterns.⁵ A hospital will be paid a set amount for patients within the normal distribution, but if the majority of these patients are above the mean in costs for that diagnosis related group, the hospital will receive less money than the actual cost of their treatment. Another hospital with patients continually below the mean would be reimbursed at the mean and make a profit on these patients. The relative use of hospital services by the patients of individual physicians becomes extremely important. A computer printout can show whether a physician used more or fewer services for a patient than the average in that

particular diagnosis related group. DRG payments to hospitals can be adjusted to take into account wage and price differentials in a particular locale.

The State of New Jersey has initiated the DRG incentive reimbursement system. Here are some of the observations there:

- a) If a hospital is able to treat a patient at a cost lower than the average for such treatment, it can keep the excess revenue as additional profit.⁶
- b) Bowing to outside and internal pressures, physicians and hospitals at the high end of the cost distribution try to conform to the mean in the short run.
- c) Hospitals tend not to market their services to categories of patients for which the hospital may suffer a loss.
- d) As hospitals become more efficient at cost containment, there are fewer areas from which to cut costs.
- e) The incentives under the DRG system will be "wiped out in two or three years."
- f) As hospitals begin to strategize within the constraints of the DRG system, major efforts will be directed at keeping costs below the mean.

Hospital management has been minimally effective in controlling the multiple costs of any individual admission. Outside forces, such as some PSROs, have had an effect on length of stay, and in certain areas have caused the exclusion of particular categories of patients from admission to the hospital. Hospital cost containment committees also have had limited success. The diagnosis related group system creates pressure within the hospital to develop a profitability scheme geared to the cost of hospitalization for a patient with a specific disease and a generally accepted treatment pattern.⁷ In hospitals at the borderline of solvency, this system obliges hospital management (board, administration, and medical staff) to review the performance of physicians in the hospital based on productivity and profitability as defined by third-party payers.

It will be interesting to see the ramifications of this reimbursement system on the practice of medicine, on the profitability of hospitals,

and on the relationship between physicians and the hospitals in which they practice. It is not clear whether DRGs as a reimbursement method will lead to more effective control of hospital costs, but it is clear that there will be renewed conflicts and tensions between providers of care and third-party payers, and between physicians and the hospitals in which they practice.

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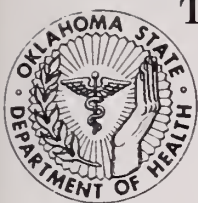
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News From The Oklahoma State Department of Health

The Pediatrics Division of the Oklahoma State Department of Health has initiated plans to implement car seat loaner programs through selected county health departments, with additional future assistance to be provided by the Oklahoma Highway Safety Office.

The infant car seat selected for loan is designed for the baby from birth to 17 pounds. Besides being easy to install and lightweight enough to be used as an infant carrier, the car restraint meets all federal safety standards, including 30 mph dynamic crash testing.

Educational materials will also be distributed as a part of the program. Studies have shown that parents are often not aware of the importance of safety restraints, are confused as to what type of seat to buy or how to properly use the seat they have, or may feel they cannot afford a car seat. The materials available are designed to address these and other issues.

The car seat loaner program will also involve the use of a community survey to identify the current usage rate and a follow-up survey on the first anniversary of the program. Tennessee, for example, was the first of 23 states to pass a law providing for the safety of children in automobiles. Two years after passage of the law, child restraint usage in Tennessee had increased 29 percent. After three years, the death rate from automobile collisions had been cut in half, and injuries to children had decreased by nearly one third.

An additional advantage of having an infant restrained is that the safety consciousness of the driver will be enhanced and, it is hoped, will contribute to increased seat belt usage by the driver.

For more information on this new project, call the Pediatrics Division at (405) 271-4471. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR JUNE 1983

DISEASE	JUNE 1983	JUNE 1982	MAY 1983	TOTAL TO DATE	
				1983	1982
Amebiasis	—	3	—	4	9
Aseptic Meningitis	39	15	19	87	37
Brucellosis	—	—	1	3	4
Encephalitis, Infectious	2	2	2	11	13
Gonorrhea (Use Form ODH-228)	1,451	1,396	1,064	7,825	7,730
Hepatitis A	45	33	46	233	333
Hepatitis B	35	29	29	147	150
Hepatitis Unspecified	12	10	17	118	123
Malaria	1	—	1	7	3
Measles (Rubeola)	—	—	1	1	—
Meningococcal Infections	4	3	2	23	16
Pertussis	36	1	14	70	3
Rabies (Animal)	14	11	13	74	115
Rocky Mountain Spotted Fever	48	16	25	79	41
Rubella	—	1	—	—	3
Salmonellosis	56	46	34	220	128
Shigellosis	13	23	29	86	136
Syphilis (Use Form ODH-228)	14	12	15	127	92
Tetanus	—	1	—	—	1
Tuberculosis	1	51	28	126	209
Tularemia	6	7	2	12	11
Typhoid Fever	—	—	—	1	2

State Physicians Offered Free Computer Information Search

On Thursday, October 6, physicians around the state will have the opportunity to call the reference staff at the University of Oklahoma Health Sciences Center Library and request, free of charge, online computer information searches on any subject they designate. The purpose of the free day is to acquaint doctors with the online search service the library provides.

Calls should be made to the library's IN-WATS number, 800-522-0222. Mail requests will also be accepted Monday through Wednesday, October 3-5, and should be addressed to Reference Services Department, OUHSC Library, PO Box 26901, Oklahoma City, OK 73190. Searches will be completed on Thursday, October 6, and mailed on Friday, October 7.

Computer printouts (bibliographies) of up to 25 citations on a requested topic will be supplied. Photocopies of the printouts will be kept on file in the interlibrary loan department, so if a physician is interested in receiving copies of the articles cited, those copies may be requested from the OUHSC Library. Photocopies of articles will be charged at the usual \$4.00 per article.

The full range of data bases from the National Library of Medicine will be available (Medline, Health Planning and Administration File, Toxline, Cancer Literature, Population Index, and Bioethics) as well as the more general interest data bases from Bibliographic Retrieval Services. BRS provides information on education, psychology, life sciences, social sciences, humanities, energy, environment, and business.

Physicians should supply a sentence or two stating the subject to be searched. If a specific aspect of a topic is desired, such as diagnosis, complications, or therapy, it should be

specified as part of the topic. Name, mailing address, and phone number should also be provided.

The event is being cosponsored by the OUHSC Library, the University of Oklahoma College of Medicine, and the Oklahoma State Medical Association. □

Tulsa County Medical Publishes Popular Health Care Guide

The 1983 "Guide to Health Services — Tulsa County, Oklahoma" was recently published by the Tulsa County Medical Society. The Guide has been issued periodically since 1977 and is sent free each month to approximately 200 new area residents. It is designed to provide newcomers with information about medical and hospital facilities in Tulsa County. Lists of new residents are furnished by the Metropolitan Tulsa Chamber of Commerce and the Broken Arrow Chamber of Commerce.

The Guide was featured last year in "Connections," the American Medical Association public relations newsletter, and the Tulsa County Medical Society received approximately 70 inquiries from other county and state medical societies across the nation. □

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National Cancer Institute Awards Funds For Research Programs

The National Cancer Institute (NCI) has awarded funds this summer to 59 community hospitals or groups of community cancer specialists in 32 states as it begins a large-scale Community Clinical Oncology Program.

Designed to combine the expertise of community physicians with ongoing research projects, the program will introduce the newest clinical research findings into community settings. It is expected to increase the number of new cancer patients involved in research studies by more than 5,000 annually.

The program will provide new information on patterns of patient care and how information about new technologies is disseminated, in addition to being a key ingredient in the NCI's effort to reduce cancer morbidity and mortality.

Almost 200 applications for the program were received from 43 states. Selection was based on technical merit, with some considera-

tion given to geographic distribution.

Among the programs funded in this region were the Arkansas Oncology Clinic, Little Rock; Presbyterian/St Luke's Cancer Study Group, Denver; St Francis Regional Medical Center, Wichita; Alton Ochsner Medical Foundation, New Orleans; and St Luke's and Baptist Memorial hospitals, Kansas City. No programs in Oklahoma were funded.

Some of the individual community programs are single clinics, groups of practicing oncologists, or single hospitals. Others are consortia of physicians and/or clinics and/or hospitals. Funding goes to each local program through a community hospital or health care organization, and treatment of patients is directed by the local physicians.

By increasing the number of patients in treatment studies, the program will reduce the time needed to find answers to important questions about new therapies. A minimum of 50 evaluable patients per year (and in many instances more than twice that number) will be entered by each of the 59 community programs on approved clinical research protocols. ☐



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Physical Therapy Association Issues Position Statement on Personnel

At its Annual Meeting in April, the Oklahoma Physical Therapy Association addressed the question of nonlicensed supportive personnel having patient care duties in physician therapy settings. The resulting position paper, recently distributed, made the following statements:

(1) The duties and necessary training shall be determined by the licensed physical therapist in charge.

(2) Training the performance of assigned duties shall be on-the-job in the employing facility.

(3) Training aids developed by those outside the employing facility may be utilized in on-the-job training.

(4) Any certification indicating completion of training shall be maintained as a permanent part of the in-house employment record only.

(5) Training received from one employer will not be transferable to another.

(6) Titles utilized to designate such positions shall apply to the employing facility only.

(7) Only a physical therapist, as defined by

statute, shall be responsible for the activities of such personnel.

(8) These personnel shall have on-site supervision by a physical therapist or physical therapy assistant, as defined by statute. □

Tulsa County Medical Society Earns Distinguished Service Award

The Tulsa County Medical Society has earned the 1983 Distinguished Service Award of the Tulsa Coalition For Older People in recognition of its efforts to favorably influence the delivery of health care for the elderly.

Dr David I. Schrum, secretary-treasurer of the 925-member physicians' organization, accepted an engraved plaque at the Coalition's annual meeting in Tulsa on June 22.

The Coalition praised the Society for publication of a brochure stressing the importance of communication between the physician and the older patient, for television programs relating to health care of the over-65 patient, for activities in corrective legislation to solve inequities and problems in the administration of Medicare, and for a mutually productive relationship with senior citizen groups. □

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Fulton Confident DHS Can Cope With Financial Difficulties

Robert E. Fulton, new director of the Oklahoma Department of Human Services (DHS), recently expressed his confidence that a workable plan for attacking DHS problems is already in operation. He cited the Bellmon Report, a 106-page survey he helped to produce in 1982 during his three months as consultant to interim DHS director Henry Bellmon.

The report, issued in January, included cost-cutting recommendations that were reflected in the 1984 DHS budget request. Fulton acknowledges that the department's monetary problems have worsened since then, but feels that the crisis will pass as unnecessary activities are eliminated and more effective, efficient work is emphasized.

He pinpoints medical care as "probably the most serious problem of public policy. The cost of medical care is growing rapidly. Our population is growing old — there are more people over 65 than ever before. We've got to find ways of taking care of these people."

Fulton thinks the Bellmon Report, with its emphasis on community-based services, shows "exactly the right emphasis" for such areas as mental retardation, juvenile services, and aging concerns. "We must try to gear state programs so people can live as normal lives as possible."

A native of St Louis, Fulton comes to the DHS from a post as senior counsel with the US

Senate budget committee, where he worked for Bellmon during the latter's second term as US senator and ranking Republican committee member.

As director of the DHS, Fulton will be heading a state agency with over 13,000 employees and a budget of over \$1 billion. He will be responsible for over 30 programs funded by the State of Oklahoma and the federal government. □

New Patient Survey Forms Now Available Free to OSMA Members

A patient survey designed to let physicians know what patients think about their office procedures and policies is now available free of charge to OSMA members.

The survey was developed under the direction of the Council on Professional and Public Relations and is aimed at improving communication between physicians and their patients.

Survey questions cover appointment and office waiting times, treatment by the physician's staff, office environment, time spent with the patient, explanations of medical problems and recommended treatments, and understanding of fees charged for services.

An initial supply of 200 survey forms, along with an instruction sheet for using the survey, will be sent to member physicians on request. Calls should be directed to Susan Meeks at the OSMA, (405) 843-9571. □

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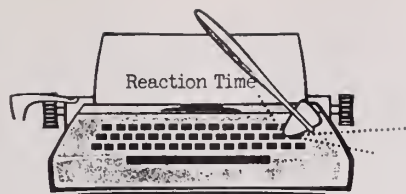
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Hospice at Home

To the Editor: With all due respect I think the article "Hospice Care Without Hospice" by Dala R. Jarolim, MD, FACP, which appeared on pp 87-89 of Vol. 76, April 1983 misses a major point of the hospice movement.

I agree wholeheartedly that good palliative care can be delivered in a traditional health care construct. As a medical oncologist, trained and certified in the 1960s and 1970s, I am glad to note this broadening of our vision of ourselves as physicians who care for patients as well as treat diseases.

But the point Dr Jarolim misses is that traditional health care is still set up to make the patient come to the care giver. When the patient is becoming progressively weaker due to a terminal illness, this becomes more and more of a problem, and transportation itself can become a source of considerable physical, emotional, and financial distress (eg, ambulance charges of \$75.00-\$200.00, one way, out-of-pocket costs to the patient/family).

Toward the end of life there is often a need to intensify availability of services *where the patient is*, ie, at home. Dr Jarolim reports 60% of her patient population died in the hospital. In the hospice programs nationwide I have been familiar with in the National Hospice Organization, 70%-80% of the patients die at home. At such times, actions of the care givers speak far louder than words — and being physically present at the bedside says far more than any telephone call.

The essence of good symptom control is accurate diagnosis: unless the care giver is at the bedside, symptom control is not anywhere near as effective, appropriate, and responsive because the skilled care giver will be dependent on the reports of unskilled observers.

Family concerns about doing this care at home relate to their lack of knowledge about the illness and a lack of confidence in their abilities to provide care. If I, as a care giver, do not know exactly what the home situation is like by being there, I find I may know the disease but I do not know the situation of the per-

son [whom] I am expecting to do the care. Also, the care giver does not as readily accept my advice because "you don't really know what it's like, doctor" is very true.

Every community that has doctors, nurses, nurse's aides, social workers, and volunteers (the "care team" of a hospice) can have a hospice. Such a team does not require additional manpower. It simply requires a restructuring of the working relationships of such care givers already in the community and a redirection of their caring focus — into the home. In this way it is a team consult to office- and institution-based care, giving both patient and localized community care givers the assurance that there is no slackening in availability, appropriateness, and continuity of care for the patient who chooses to die at home.

And in conclusion, that is where the cost savings of hospice are made. Fifty-five percent to 60% of hospice patients never return to an institution. Greater than 80% of all patient care days are in the home setting. Hospice programs do give competent and effective care. They can provide such care in the home, which is where patients prefer to be. And [these programs] can do so at a savings to a society which is realizing that health care is far too expensive in its present style of operation.

Daniel C. Hadlock, MD
Medical Director
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Book Review

Head Injury. Edited by Paul R. Cooper, MD, Baltimore: The Williams and Wilkins Company, 1982. 412 pages. \$49.00.

Head Injury is a multi-authored book about the management of head injury and is written primarily for the practicing neurosurgeon. It would be useful to any physician, however, who is called upon to care for the patient with a head injury, from the emergency room physician to the neurologist or general surgeon. The 25 authors are multi-disciplinary as well, and include well-known neurosurgeons, plastic surgeons, neurologists, psychologists, pathologists, neuroradiologists, and internists from several different institutions. Their various points of view are reflected in these twenty

chapters, which thoroughly cover the subject of head injury.

Specific types of injuries such as gunshot wounds of the brain, injuries of the cranial nerves, or traumatic cerebrospinal fluid fistulas are grouped in individual chapters so that they may be easily referenced. More global issues, such as the initial evaluation, medical management of intracranial pressure, and management of the multiply injured patient, are dealt with in other chapters.

Each chapter is amply illustrated, and the radiographic examples are of excellent quality. An exhaustive, up-to-date list of references is given, perhaps the book's most outstanding feature.

As in any multi-authored text, there is some redundancy. But overall, the individual authors *do* present, in a dispassionate fashion, a balanced, eclectic point of view on controversial issues and thereby have accomplished their stated goal.

Jeanne Ann King, MD
Department of Neurology
University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Deaths

HILLARD E. DENYER, MD
1917 - 1983

Bartlesville general surgeon Hillard E. Denyer, MD, died in Tulsa August 8 at the age of 65. He was a member of the OSMA Board of Trustees and a past president of the OSMA (1969-70). A past president of the Oklahoma Foundation for Peer Review, Dr Denyer was also a former trustee for the Oklahoma Medical Research Foundation and the University of Oklahoma College of Medicine Alumni Association. Dr Denyer was born in Meeker and graduated from the OU College of Medicine in 1941. He established his practice in Bartlesville in 1947 after serving as a flight surgeon in World War II. He was a Fellow of the International College of Surgeons and a member of the American Society of Abdominal Surgeons.

AARON C. LITTLE, MD
1907 - 1983

Aaron C. Little, MD, died at his home in Minco on July 1, 1983. Born in Texas, Dr Aaron moved to Custer City, Okla, and graduated in 1931 from the University of Oklahoma College of Medicine. He established a general practice in Minco in 1932 and, except for his years as a US Navy doctor during World War II, remained there until his retirement in 1974. Dr Aaron held a life membership in the Oklahoma State Medical Association.

In Memoriam

1982

<i>Clyde E. Harris, MD</i>	<i>September 1</i>
<i>Tillman A. Ragan, MD</i>	<i>September 5</i>
<i>Floyd T. Hubbard, MD</i>	<i>September 23</i>
<i>William A. Eastland, MD</i>	<i>October 3</i>
<i>William J. Craig, MD</i>	<i>October 19</i>
<i>William M. Wood, MD</i>	<i>October 30</i>
<i>Hugh C. Graham, Sr, MD</i>	<i>November 11</i>
<i>John David Wilson, MD</i>	<i>November 11</i>
<i>Clinton Gallaher, MD</i>	<i>November 15</i>
<i>Bert F. Keltz, MD</i>	<i>November 30</i>
<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

<i>Dewey K. Rhea, MD</i>	<i>January 3</i>
<i>Fred C. Buffington, MD</i>	<i>January 4</i>
<i>C.D. Cunningham, MD</i>	<i>January 26</i>
<i>William S. Jacobs, MD</i>	<i>February 9</i>
<i>John R. Little, MD</i>	<i>February 11</i>
<i>L.A.S. Johnston, MD</i>	<i>February 16</i>
<i>Selwyn A. Willis, MD</i>	<i>March 3</i>
<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
<i>George M. Adams, MD</i>	<i>May 3</i>
<i>John R. Reid, Jr, MD</i>	<i>June 14</i>
<i>Gilbert E. Haslam, Jr, MD</i>	<i>June 15</i>
<i>Thomas A. Trow, MD</i>	<i>June 23</i>
<i>Richard D. Mullett, MD</i>	<i>June 28</i>
<i>Aaron C. Little, MD</i>	<i>July 1</i>
<i>Michael C. Manning, MD</i>	<i>July 3</i>
<i>Hillard E. Denyer, MD</i>	<i>August 8</i>

MISCELLANEOUS ADVERTISEMENTS

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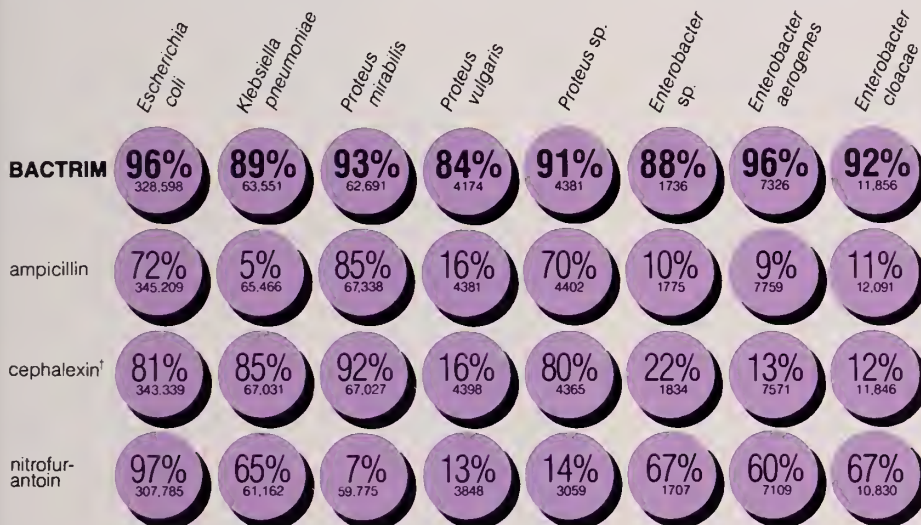
In vitro studies demonstrate



Bactericidal activity

with minimal resistance

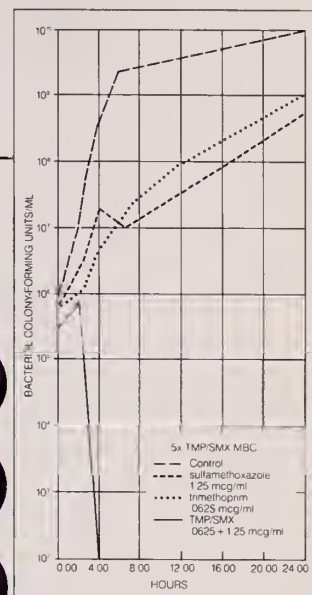
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



†Analogous to cephalothin, the primary antibiotic disc used in testing.

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82. Numbers under percentages refer to the projected number of isolates tested.

RAPID IN VITRO DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli* in vitro.¹

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.⁶⁻¹¹

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. for recurrent urinary tract infections

**In vitro* data do not necessarily predict clinical results.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Maunz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Irvani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaefer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim® DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: **BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS.** Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: **General:** Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: **Teratogenic Effects:** Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, perianteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some glycosides, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: **Not recommended for infants less than two months of age.** **URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:**

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: **Double Strength (DS) tablets**, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; **Tel-E-Dose®** packages of 100; **Prescription Paks of 20 Tablets**, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; **Tel-E-Dose®** packages of 100; **Prescription Paks of 40 Pediatric Suspension**, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). **Suspension**, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

References:

- Stone PH, Turi ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
- Antman E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary artery spasm: Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY

PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: 1. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g. where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: **Excessive Hypotension:** Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: **General:** **Hypotension:** Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianaginal effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%; palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request

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PFIZER INC.

"I can do things that I couldn't do for 3 yrs. including joining the human race again."



*Quotes from an unsolicited
letter received by Pfizer from an
angina patient
While this patient's experience
is representative of many
unsolicited comments received,
not all patients will respond to
Procordia nor will they all
respond to the same degree*

*"My daily routine consisted of
sitting in my chair trying to stay alive."*

*"My doctor switched me to
PROCARDIA[*] as soon as it became
available. The change in my condition
is remarkable."*

*"I shop, cook and can plant
flowers again."*

*"I have been able to do volunteer
work...and feel needed and useful
once again."*

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



for the varied faces of angina

PROCARDIA[®] **(NIFEDIPINE)** Capsules 10 mg

Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA brief summary on adjoining page

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ibuprofen, Upjohn

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Upjohn

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In vulvovaginitis, Triva[®] douche powder provides symptomatic relief in seconds.

Relief in seconds. That's how quickly Triva goes to work to help your vaginitis patients. And that's just after their first douche. Within 12 days of recommended treatment with Triva, most cases of trichomonal and non-specific vaginitis are organism-free. (Monilial infection may take a bit longer.) Also, your patients can start therapy right away, because with Triva there's no need to worry about contraindications associated with causative organisms.

Triva[®] Douche Powder

Oxyquinoline Sulfate 2.0%, Alkyl Aryl Sulfonate 35.0%, Sodium Sulfate 52.5%, Disodium EDTA .33%.

Combines flushing douche action with the chemical action of its formula. For treatment of Trichomonas infestation, Triva Douche Powder may be used adjunctively with oral therapy for fast symptomatic relief.

x Triva[®] Jel

Per 5 grams: oxyquinoline benzoate 7.5 mg.; alkyl aryl sulfonate 62.5 mg.; disodium edetate 2.5 mg.; aminacrine HCl 10 mg.; copper sulfate .063 mg.; sodium sulfate 6.9 mg.

Provides the effective therapeutic action of Triva with the continuous action of the jel form, to quickly arrest infection and aid in relief of symptoms.

x Triva[®] Combination

Combines therapeutic Douche Powder and Triva Jel with a handy applicator in a convenient, complete treatment kit. Triva Combination effectively treats all three types of vaginitis, including stubborn cases where Monilia and Trichomonas occur together. Effectiveness of Triva Combination has been demonstrated

by clinical testing involving the use of Papanicolaou smear and Sabouraud culture to confirm diagnosis and cure.

Precaution

If irritation occurs at the onset of treatment with Jel, treatment may be postponed for a day or two and preliminary treatment with ½ strength Triva Douche used. Regular treatment should then be resumed.

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- Digolase . . . Digestive enzymes
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Please see brief summary of prescribing information on the next page.

Candidates for nutritional therapy...

Brief Summary of prescribing information

RU-TUSS®

TABLETS

INDICATIONS AND USAGE: Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues.

CONTRAINDICATIONS: Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS: Ru-Tuss Tablets may cause drowsiness. Patients should be warned of possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS: Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See WARNINGS:).

OVERDOSAGE: Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS: Hypersensitivity reactions such as rash, urticaria, leukopenia agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION: Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

Federal law prohibits dispensing without prescription.

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*Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1084.
Please see summary of product information on reverse page.

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Before prescribing, please consult complete product information, a summary of which follows:

Each Berocca[®] Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *d,l*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B₁ (as thiamine mononitrate), 20 mg vitamin B₂ (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B₆ (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B₁₂ (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.

WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

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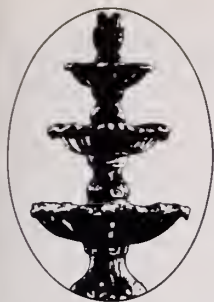
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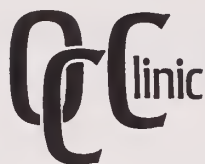
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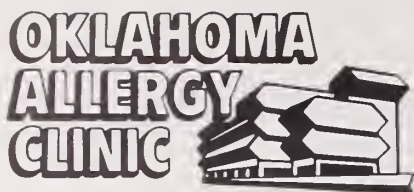
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Members of the Oklahoma State Medical Association, the constituent societies of the association, and all readers in general are invited to supply news items of general interest to the profession.

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Authors will receive reprint order forms from the Transcript Press, PO Drawer 1058, Norman, Oklahoma 73070, prior to final publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

BACK ISSUES

Microfilm copies of back issues of *The Journal* may now be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

FULL STEAM AHEAD is our theme for 1983-84 and this summer we have certainly been "getting up steam" in preparation for a "fast track" this fall.



The Long Range Planning Committee had a productive meeting where plans were made for developing a People Bank, listing the skills of members so they can be tapped in a variety of ways rather than being limited to a given job or position. A day was spent updating materials for our Nurses Loan Fund. And for the past year we have been planning our first two-day educational conference. This will be held at the Park Suite Hotel in Oklahoma City on Monday, September 26th and Tuesday, September 27th. In addition to Dr Marsha Schuchard, who was featured on this page last month, we will have Lorre Lei Jackson, Terry Fife, and Dr Jean Cooper with us. Lorre Lei hails from Louisiana and is our special AMA Auxiliary guest. She is a member of the AMAA's Health Projects Committee. Her special area of concern is Substance Abuse/Drunk Driving. She will address these issues Monday and Tuesday of the conference. Terry Fife is the prevention coordinator with the Oklahoma Department of Mental Health and she will be with us at the Tuesday session to answer questions concerning programs available in Okla-

homa. On Monday afternoon Dr Jean Cooper will speak to us about mental retardation. It promises to be an exciting meeting. The hotel is lovely and the menus sound delicious. We hope to see you there!

We have many plans for the coming year involving AMA-ERF, Legislation, Community Health, Doctor's Day, and Membership. You will be hearing from these chairmen in future issues. A membership brochure is being developed to be used to Renew, Recruit, Refresh, Reactivate, and Reach Out to members. We're enthusiastic about this new membership tool. It's just in time, too, because we have been challenged by the Kentucky Auxiliary to a membership contest. So, if you have not paid your dues or if your spouse has not paid his or her dues, please do! We have much to offer!

Your OSMA Auxiliary officers look forward to visiting in your county auxiliary. We are always fascinated with the accomplishments in each community. This is also an opportunity to become better acquainted and is certainly a pleasure for us.

There is much to accomplish this year, but with a membership of dedicated volunteers we can anticipate a successful 1983-84. So COME ABOARD OUR AUXILIARY EXPRESS and share these accomplishments with us.

*Camille Harrison, President
OSMA Auxiliary*

The 77th Annual Scientific Assembly of the Southern Medical Association (SMA) will be held November 6-9 at the Baltimore Convention Center, Baltimore, Maryland. There is no fee for registration. Postgraduate courses are \$15 for SMA members, and \$22.50 for nonmembers. Those wishing to attend should contact Ms Jeanette Stone, Southern Medical Association, PO Box 2446, Birmingham, Alabama 35201, (205) 323-4400.

"Critical Issues in Health Law" is the theme of an October 13-14 meeting sponsored by the American Society of Law and Medicine. To be held at the Westin Hotel Copley Place in Boston, the meeting will address such issues as health care financing — legal, medical, and ethical considerations; medical malpractice; impaired health care providers; and new developments regarding handicapped newborns and informed consent. The meeting is open to members, non-members, and students; registration information can be obtained from Barbara Schneider, Conference Registrar, American Society of Law and Medicine, 765 Commonwealth, Boston, MA 02215.

Mercy Health Center, Oklahoma City, is announcing Parts I and II of a series of conferences in endocrinology for practicing physicians. "Thyroid and Parathyroid Diseases" is the topic of the November 2 conference, and "Use of Estrogens and Anti-Hypertensive Drugs" is scheduled for December 1. Both will be held at the Greens Country Club from 11:00 A.M. to 3:30 P.M. Each of the conferences is CME accredited for four hours. Registration information is available by calling (405) 755-1515, extension 2603.

"Internal Medicine in the Future" will be discussed at the October 27-30 Annual American College of Physicians-Oklahoma Society of Internal Medicine Regional Meeting to be held at Shangri-La Lodge, Grand Lake. The education and research program for internists will cover such topics as the clinical significance of new biology, AIDS update, new technologies in internal medicine, and acute myocardial infarction and meets the criteria for CME credit in Category 1. For information and/or registration materials contact Kay Bickham, 601 Northwest Expressway, Oklahoma City, Oklahoma 73118.

The Fall Scientific Meeting of the Oklahoma Occupational Medical Association will be held in Tulsa on Friday and Saturday, November 4 and 5. The program has been designed to enhance the clinical knowledge and skills of health professionals involved in occupational medicine. Registration is open to physicians, physician assistants, occupational nurses, industrial hygienists, and others interested in occupational medicine. For program and registration contact G. W. Prothro, MD, 2808 South Sheridan, Tulsa, Oklahoma 74129.

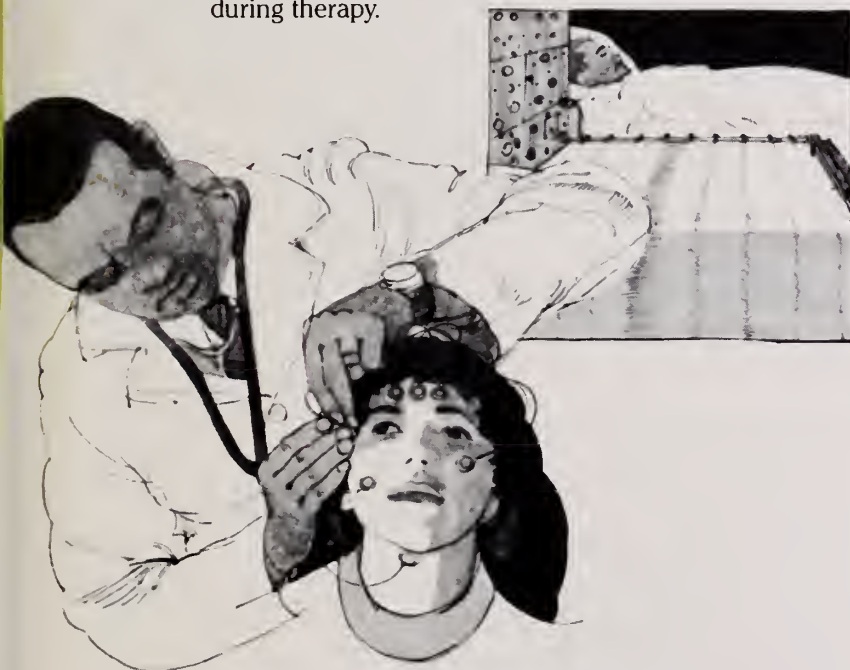
The Oklahoma Physicians Winter Seminar will be at Copper Mountain, Colorado, December 26-January 2. The program is produced by Contemporary Medical Educators in conjunction with the Office of Continuing Medical Education, Oklahoma University College of Medicine; it will feature presentations by both faculty members and registrants. Registrations and accommodations are limited. For information write Irwin H. Brown, MD, 5700 NW Grand Boulevard, Oklahoma City, Oklahoma 73112, or call (405) 946-0548.

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sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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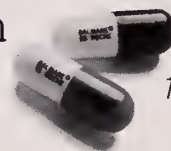
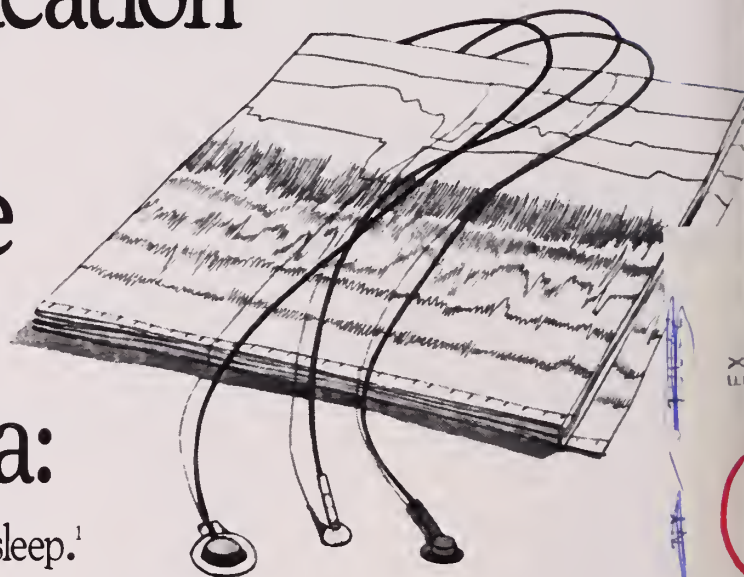
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An added complication... in the treatment of bacterial bronchitis*

Increasing incidence
of ampicillin resistance in
Haemophilus influenzae

Ampicillin Resistant
Haemophilus influenzae

H. influenzae

S. pneumoniae

Brief Summary: Consult the package literature for prescribing information.

Indications and Usage: Cefclor* (cefadroxil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics including Cefclor should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics including macrolides, semisynthetic penicillins, and cephalosporins; therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: **General Precautions:** If an allergic reaction to Cefclor occurs, the drug should be discontinued, and if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies in transfusion cross-matching procedures when hemagglutination tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with less-labile glucose enzymatic test strips (USP-Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cefclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed.

Nursing Mothers—Small amounts of Cefclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁵

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefadroxil

Pulvules®, 250 and 500 mg

hour. The effect on nursing infants is not known. Caution should be exercised when Cefclor* (cefadroxil, Lilly) is administered to a nursing woman.

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cefclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefclor. Such reactions have been reported more frequently in children than adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Cefclor is the usual drug of choice in the treatment and

prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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The Journal of the Oklahoma State Medical Association (USPS 285-000)

Roche salutes the history of Oklahoma medicine

PUTTING THE PAP TEST ON WHEELS



Introducing the new cancer detection procedure for women to rural areas was a challenge well met by the Oklahoma Division of the American Cancer Society when, in 1946, it converted an obsolete school bus into the nation's first cancer clinic on wheels.

Staffed by volunteer specialists—an internist, a dermatologist, a gynecologist and a surgeon—and one salaried secretary to handle the record-keeping, the recycled vehicle left Oklahoma City and headed north. Its first stop was Tonkawa,^{1,2} where advance publicity had drawn women from nearby towns, farms and reservations, all seeking the proffered examinations.

Cooperative effort

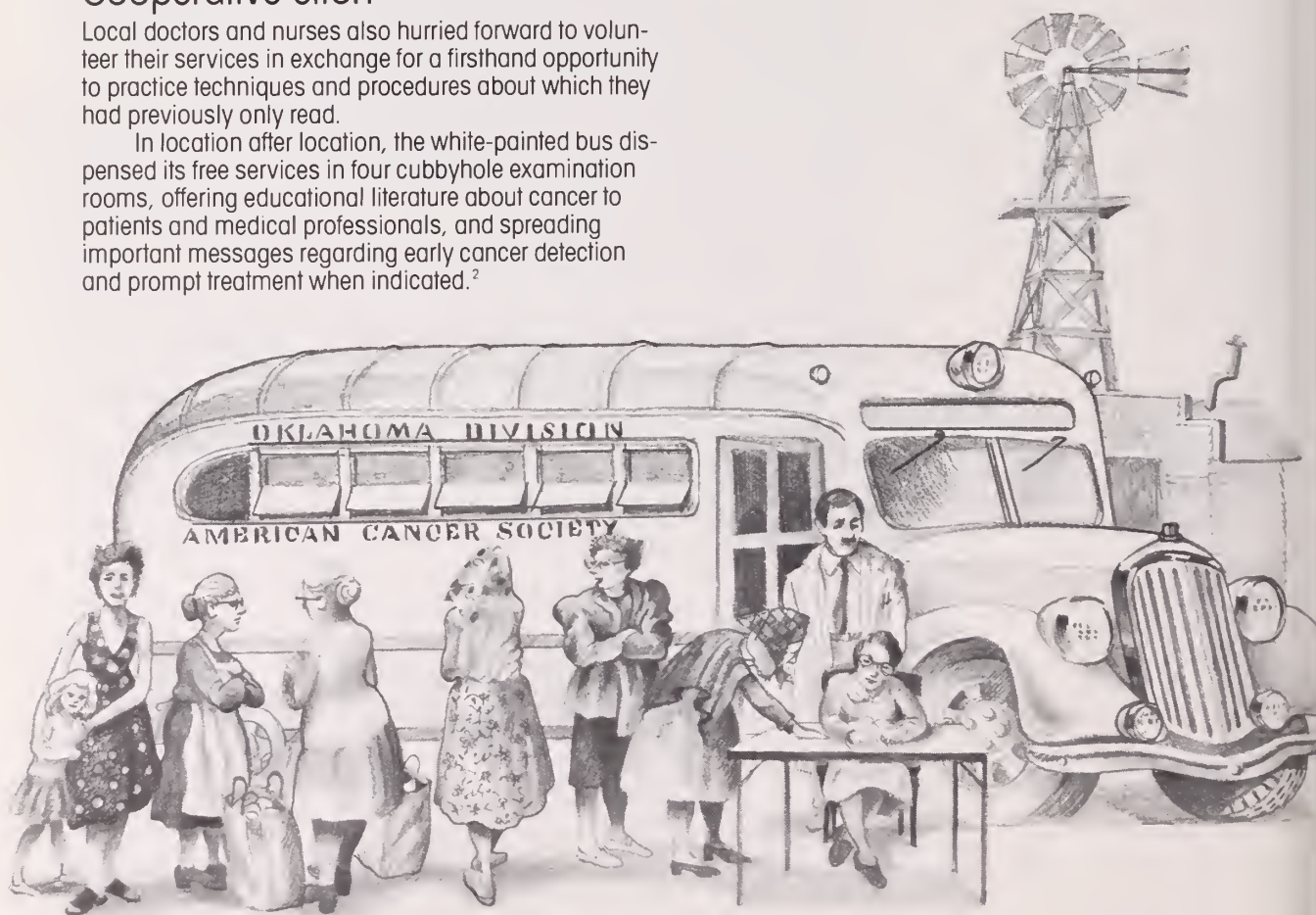
Local doctors and nurses also hurried forward to volunteer their services in exchange for a firsthand opportunity to practice techniques and procedures about which they had previously only read.

In location after location, the white-painted bus dispensed its free services in four cubbyhole examination rooms, offering educational literature about cancer to patients and medical professionals, and spreading important messages regarding early cancer detection and prompt treatment when indicated.²

The idea caught on

Today, it is not surprising to see a modern medical services vehicle on wheels in shopping-center parking areas, schoolyards or business centers. Community service organizations sponsor and support them all across the country. Unquestionably, they have come a long way in equipment and comfort from the school bus that pioneered vital health services...but *it* was the bus that made medical history.

References: 1. Kane JN *Famous First Facts*, 3rd ed. New York, The H. W. Wilson Co., 1964, p. 367. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.



When the history reveals anxious depression...

For the estimated 70 percent of nonpsychotic depressed patients who are also anxious,¹ Limbitrol provides both amitriptyline, specific for symptoms of depression, and the effects of Librium® (chlordiazepoxide HCl), the tested and dependable anxiolytic. Limbitrol is, therefore, a better choice for these patients than dual agents that contain a phenothiazine, a class of antipsychotic drugs used infrequently in nonpsychotic patients.¹

62% of Overall Improvement...Within the First Week

Limbitrol also has a rapid onset of action which may lead to greater patient compliance. In a multicenter study, patients taking Limbitrol experienced 62% of their overall improvement within the first week of therapy.²

In another multicenter study,³ the following symptoms associated with anxious depression were significantly reduced during the first two weeks of therapy:

- ☐ Headache—79%
- ☐ Early insomnia—91%
- Middle insomnia—87%
- Late insomnia—89%
- ☐ Gastrointestinal upset—73%

In two multicenter studies, only 1.9% of Limbitrol patients experienced cardiovascular side effects.³

Patients should be cautioned about the combined effects with alcohol or other CNS depressants and about activities requiring complete mental alertness such as operating machinery or driving a car.

References: 1. Rickels K. Drug treatment of anxiety, in *Psychopharmacology in the Practice of Medicine*, edited by Jorvik ME, New York, Appleton-Century-Crofts, 1977, p 316. 2. Feighner JP *et al*: *Psychopharmacology* 61: 217-229, Mar 1979. 3. Data on file, Hoffmann-Lo Roche Inc., Nutley, NJ

In moderate depression and anxiety

Limbitrol®

Tablets 5-12.5 each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline
(as the hydrochloride salt)

Tablets 10-25 each containing 10 mg chlordiazepoxide and 25 mg amitriptyline
(as the hydrochloride salt)

Please see summary of product information on following page.

LIMBITROL® TABLETS (Tranquiliizer—Antidepressant)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of moderate to severe depression associated with moderate to severe anxiety

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.

Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).

Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated. Sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, over-sedation, confusion or anticholinergic effects.

Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.

The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:

Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke

Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido

Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.

Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract

Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus

Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia

Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue

Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female and elevation and lowering of blood sugar levels

Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling

Overdose: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.

Limbitrol 10-25, initial dosage of three to four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol 5-12 5, initial dosage of three to four tablets daily in divided doses, for patients who do not tolerate higher doses.

How Supplied: White, film-coated tablets, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) and blue, film-coated tablets, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100, Prescription Paks of 50.

RU-TUSS® II

sustained release capsules

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated patient, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdose is symptomatic and supportive. In the event of overdose, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

HOW SUPPLIED: Green and clear capsules with green and white beads. Bottles of 100 tablets. NDC 0524-0031-01

Store at controlled room temperature 15-30°C (59°-86°F).

CAUTION: Federal law prohibits dispensing without prescription.

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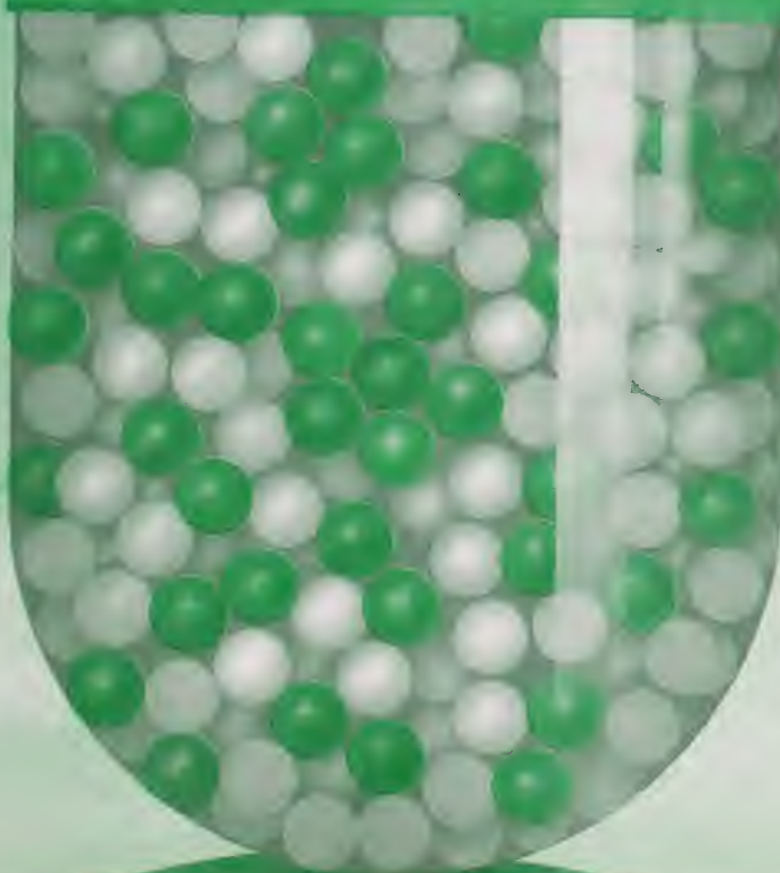
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Awaiting Your Reply

Looking through our file of unanswered correspondence I found a few letters worth sharing. As events unfold, it becomes easier to understand the silence of some of the addressees although, I should admit, I never really expected a response from any of them. (Matter of fact, I never actually wrote any of these letters, but at least, I thought about it.)

Dear Mr President:

I would like to know how much the telephone company charged you for your "Baby Doe" hotline and who paid for all those investigators who went out to change the doctors' minds.

Also, if it's not too much trouble, I would like to know who was going to pay the hospitals' bills and the doctors' fees connected with the "new decision," and during all the years that follow.

And do you think you'll have much trouble finding doctors who will take the cases after the regular ones are fired? Of course, congress could always pass a law of some kind.

I guess the best thing to do is just let the courts straighten out the whole mess. Together with congress, they practice real good medicine because they have all those experts from the medical center faculties so close at hand there in the East.

Dear Secretary of Defense:

At your earliest convenience I would appreciate your estimate of how much it would cost to fly a liver from Los Angeles to Boston via Air Force jet.

Will you accept an assignment from my insurance company as payment in full?

Dear Social Security Director:

I was just wondering if you have sent brochures to all your beneficiaries explaining about these Diagnostic Reimbursement Groups (DRGs) and encouraging them to call you if they have any

questions about it, so, I thought I'd write and just ask.

I think it would be great if you would explain how, under this brilliant new plan, the hospitals that do the least for their patients will make the most money. That's a real stroke of genius.

P.S. Would you please send me your phone number? Will I be able to contact you 24 hours a day, 7 days a week?

Dear FTC Chairman:

I would like very much to learn how much more, on the average, it would cost to have my gallbladder removed by a surgeon who does not advertise as compared to one who does.

Do you know of any way I can force my favorite surgeon to advertise so his fees will come down? There must be a way.

Dear VA Medical Director:

I would like to know how many patients you have in your hospitals, how many are out on leave or pass, and how you are able to get paid for all those in-patients who are out? Also, please tell me what your actual per diem costs are, figured the same way Medicare figures them. Or is there some law against revealing your per diem costs? If so, why?

Forgive me if I seem impertinent, but I keep hearing that as soon as the government takes over all the hospitals we'll all get a lot better care for a lot less money. And, as yours are the best of the government-run hospitals, I'd like to know how much less it costs you to care for one patient for one day than it costs these private hospitals.

Dear Medicare:

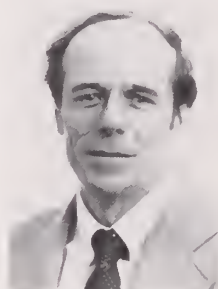
I would like to know what your overhead costs are and how many cents of every dollar you *collect* — not *spend* — goes to physicians.

Very truly yours,

— MRJ

How Many Is Enough?

The answer to "How much is enough?" certainly depends on a lot of things, which sounds like a quote from *Alice in Wonderland*. The "enough" level of mosquitoes is often reached before the "enough" level of fishing.



"How many physicians are enough for Oklahoma?" is certainly a complex question. The very thorough GMENAC report has been widely quoted as predicting a physician surplus and has also been widely debated by authoritative figures. Locally, the thorough paper by Dr C.S. Lewis, Jr, in the *OSMA Journal* in April of this year, concluded that current class sizes of Oklahoma medical schools should not be changed. This would result in approximately one-third of all practicing physicians in Oklahoma being osteopathic physicians. With our relatively favorable malpractice climate and a growing national surplus of physicians, Oklahoma may well be experiencing increasing immigration of physicians, including graduates of foreign medical schools. Our Physician Manpower Training Commission has a splendid record of success in this complicated area.

With this background, our Council on Planning and Development appointed a special

study committee, chaired by Dr Tom Lynn, in October of 1982. This committee reported its recommendation to our Board at the August meeting. The outcome of this excellent work was an important letter recently sent to Dr Joe Leone, Chancellor of the Board of Regents for Higher Education.

Our letter to Dr Leone emphasizes that a study of physician manpower in Oklahoma must involve not only the state-supported schools of allopathic and osteopathic medicine, but also the private school of medicine at Oral Roberts University. Our letter asks Dr Leone to appoint a study group and prepare a report analyzing possible physician overproduction.

The cost to all taxpayers in Oklahoma is estimated at approximately \$150,000 per graduating medical student. Overproduction of physicians would be a great cost to Oklahoma taxpayers. We recognize that it is a long pipeline from a freshman's first day in medical school to a physician's first day in practice. Additionally, we are well aware that the quality of our medical graduates at all of our colleges of medicine is of the highest importance, and that adequate numbers of skilled physicians are needed, particularly in some of our smaller communities.

Chancellor Leone is very well regarded as a knowledgeable educator and able administrator. We anticipate the Regents' study of physician manpower with great interest.

George H. Kamp, M.D.

An Appraisal of Neonatal Intensive Care Unit Weight-Specific Mortality Rates

SAMUEL SEPKOWITZ, MD

Successes of neonatal intensive care units appear overstated as a result of changing forms of patient selection bias which are pervasive and persistent.

The establishment, in 1948, of the New York City premature centers was among the pioneer efforts of the specialized management of low-birth-weight (LBW) infants and of other newborns requiring special care.¹ This effort was a response to numerous reports indicating that the majority of newborns who die do so within the first few hours or days of life. Although these centers did not employ techniques that characterize the neonatal intensive care unit

(NICU) of today, they were precursors of the NICU. Attached to the obstetrical units they served, the centers were also commissioned to accept referrals.^{2,3} Very soon after their establishment, the centers began to report success in lowering the neonatal mortality rate. It quickly became evident that there was a relationship between the neonatal death rate in the first 24 hours and the selective composition of the population that survived long enough to be referred for treatment. Wallace reported that the older the newborn when transferred, the greater its chance for survival.¹ Mortality records of the premature centers (1950-1957) disclosed that outborn LBW infants had better survival rates than inborn infants of corresponding weights.³

Silverman, in an exhaustive analysis of referral bias, warned that errors and distortions would be introduced into neonatal mortality rates unless inborn and outborn mortality rates were calculated separately.⁴ To eliminate such bias, he devised a formula for computing standardized death rates for nurseries which took into account the distortions produced by transferring practices as well as by sex and

race. He then studied the population in the ten New York premature centers (1955-1957) and showed the superior survival rates for outborn prematures. In addition, he tabulated hourly age at death of inborns and outborns during the first two hours and by greater time intervals thereafter.⁵

NICUs have replaced premature centers, but the problem of referral bias remains.⁶ The time required to transfer infants during a period of high mortality risk is a crucial selective force. The purpose of this report is to ascertain hourly mortality rates during the first 24 hours for white inborn infants at a community hospital with a Level II nursery and to demonstrate the relevance of the data in evaluating recently reported NICU weight-specific mortality rates.

Methods

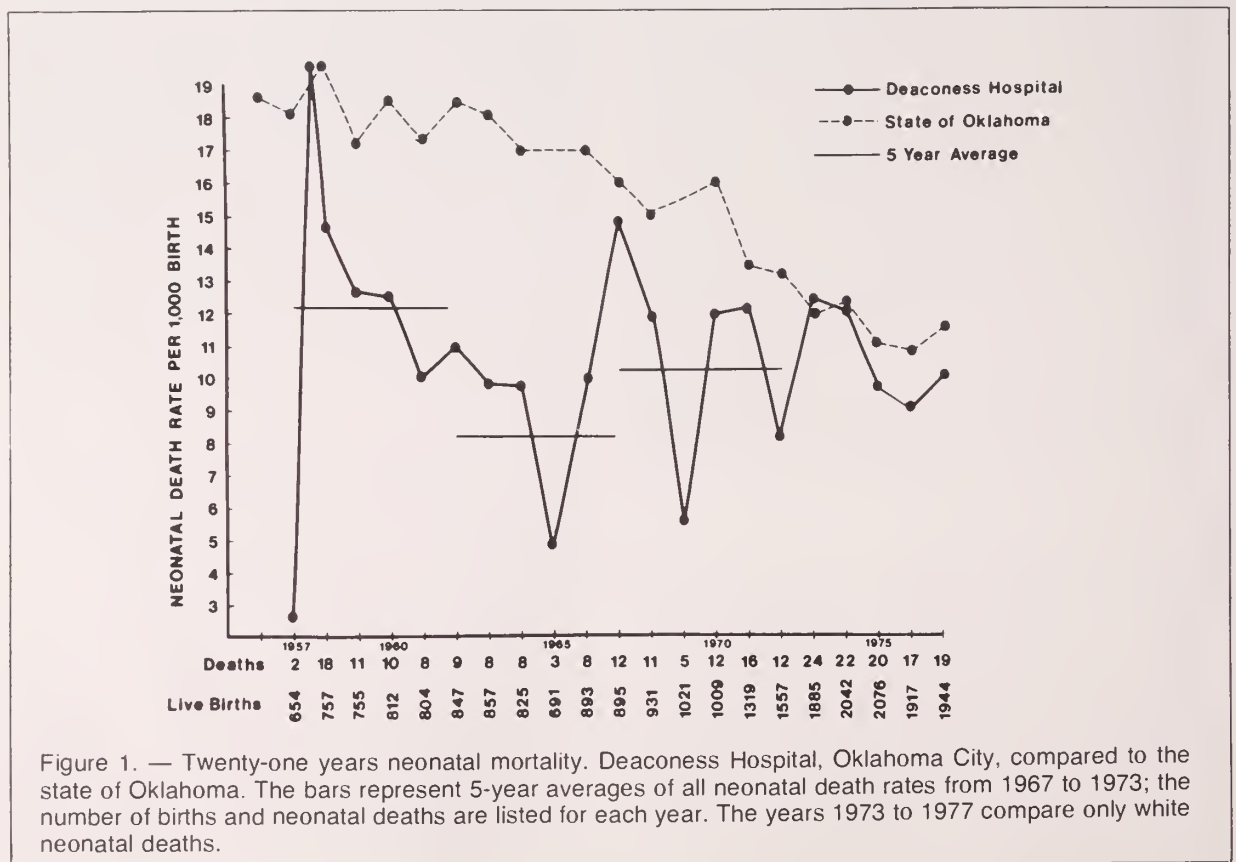
Deaconess Hospital, Oklahoma City, is a community hospital with a Level II newborn facility. It provides assisted ventilation by bag, mask, or endotracheal tube, and parenteral support. The nursery has no mechanical venti-

lation equipment or service. Neonatal mortality data were obtained from records of the hospital's newborn nursery. Information about total deliveries, birth weights, and race for the years 1973-1977 was obtained from the obstetrical log. A record of all transferred-out neonates was kept during this five-year period and includes the outcome of these transfers.

Results

Figure 1 shows the rates for births and neonatal deaths over a 21-year period (1957-1977) at Deaconess Hospital. Five-year averages are represented for the first 15 years since the number of births was small. For comparison, the neonatal deaths in Oklahoma are shown for the same period.⁷ Statistics for 1973-1977 refer to white neonates only (personal communication, Mary I. Ward, Oklahoma State Department of Health, Maternal and Child Health Service, 11/7/78). White infants constituted 96.6% of all births at Deaconess Hospital in the five-year period. Neonatal mortality varied little in the 21-year period, holding at approximately ten neonatal deaths per 1,000 live births.

Deaconess Hospital recorded 9,867 live



births from 1973-1977 of which 9,527 were white neonates, and 83 twin deliveries. Table 1 shows the annual occurrence in each birth-weight category. The five-year white LBW percentage of 6.03% compares with the 6.3% national average in 1974.⁸

There were 98 white neonatal deaths in the five-year period. Figure 2 relates the incidence of death, birth weight, and age at death in hours. The time at which the physician pronounced death appears on the hospital chart and on the discharge sheet. 82.8% of the deaths occurred in newborns under 2,500 g. 60.7% were in neonates less than 1,500 g. Deaths within the first 24 hours accounted for 64.7% of all the neonatal mortalities. Half of all the deaths occurred in the first twelve hours, 39.8% in the first eight hours, 27.5% in the first four hours, 24.4% in the first three hours, and 10.8% in the first hour.

Discussion

Neonatal mortality at Deaconess Hospital over a 21-year period shows no definite trend, averaging slightly over ten deaths per 1,000 births annually when five-year averages eliminate the large fluctuation caused by small numbers of births in the earlier years (Fig 1). During this time neonatal management by the pediatric staff has varied little. The paramount emphasis of treatment is on minimal handling. In the nursery, oxygen is administered in concentrations necessary to abolish cyanosis, reduce respiratory rate, and avoid apnea. Bagging is employed for prolonged apnea. Capillary blood gases are used chiefly to monitor oxygen administration. There has been a trend toward earlier feedings and intravenous-fluid therapy, but restriction of handling has always been emphasized. In contrast to Deaconess Hospital, neonatal mortality in Oklahoma has shown a definite decline during the 21-year period.⁷ While the annual rate of decline has not been calculated for Oklahoma, it appears similar to that of the United States, which declined 5% per year from 1965 to 1975 (Kleinman).⁹

Figure 2, relating birth weight and age at death during the first 24 hours, shows that 24.4% of all neonatal deaths occurred in the first three hours. Thereafter, the probability of death decreased with each hour of survival. As expected, the greatest number of deaths, 40 of 98, occurred in the <1,000 g weight group. Of this group, 40% died within three hours. Usher

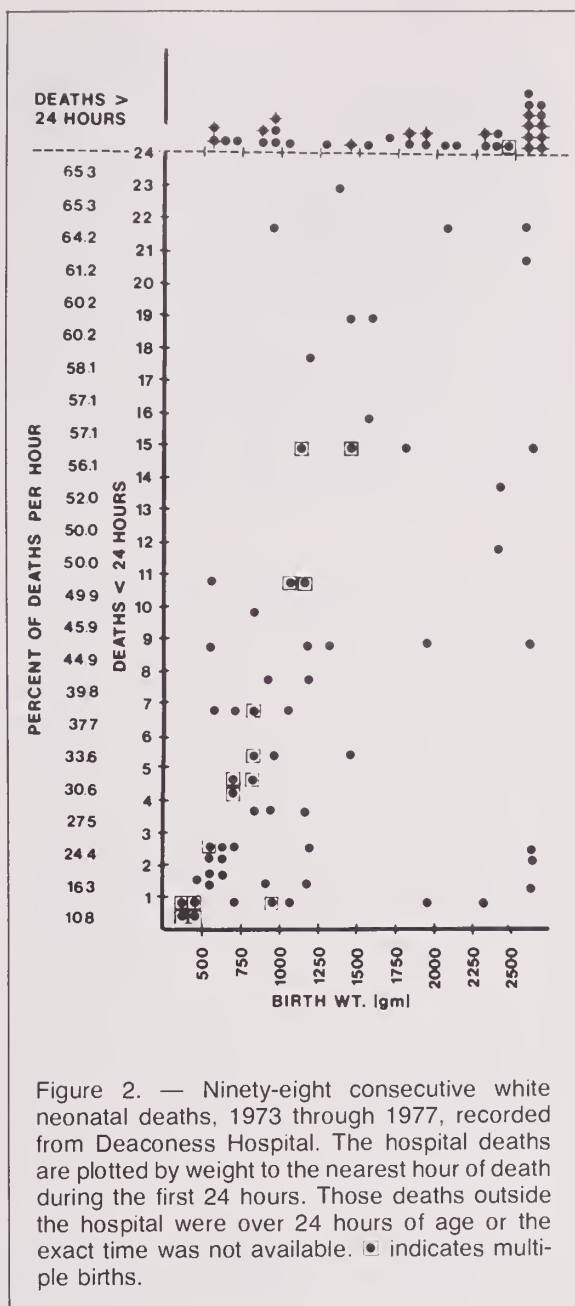


Figure 2. — Ninety-eight consecutive white neonatal deaths, 1973 through 1977, recorded from Deaconess Hospital. The hospital deaths are plotted by weight to the nearest hour of death during the first 24 hours. Those deaths outside the hospital were over 24 hours of age or the exact time was not available. ■ indicates multiple births.

reported that in Quebec 44.9% of first-week deaths (501 to 1,000 g) occurred within three hours.¹⁰ In this weight group, 23.4% died within three hours at the Royal Victoria Hospital, where neonatal intensive care was available.¹⁰ Silverman reported that 20.5% of all deaths in infants weighing <1,000 g occurred within two hours of birth; 47% of this group died in less than six hours.⁵

The hourly white neonatal mortality rates from the United States vital records include only the first hour (13.6%) and the first 24 hours (53%).¹¹ This compares to 10.8% and 65% at Deaconess Hospital for corresponding hours.

From 1969 to 1979, the Vermont neonatal death rate in ages under 24 hours declined from approximately 65% to 57%.¹² This decrease may have resulted from intensive care intervention that delayed the time of death.¹³

In the larger weight groups (>2,000 g), the hourly death rate is reversed. Only 14% of the total deaths within this group occurred in less than three hours, and 60% of these infants were over 24 hours of age. This weight group may have a different impact on the neonatal mortality rate of the referral center that receives them, since they have additional health problems and may have a higher mortality rate.³

Birth weight, which is the most objective expression of gestational age, is generally regarded as the principal predictor of neonatal mortality. The 6.03% LBW and the distribution in birth-weight-specific categories as seen in Table 2 suggest that the Deaconess Hospital population approximates a random white population at the time under study.⁸ Particular care was taken to ensure that all live births, weights, and deaths were recorded. Hospital-based data are likely to be more accurate than government statistics, in which some birth weights are not recorded and an appreciable number of deaths are not registered. McCarthy found that 21% of all neonatal deaths were missing in the vital records of Georgia (1974-1977).¹⁴ Hospitals, however, may also have difficulties with death registration. The Collaborative Perinatal Study has no weights

on 11.8% of white deaths and 13.4% of black deaths, limiting any attempts to establish weight-specific neonatal mortality rates.¹⁵

The annual LBW percentages at Deaconess Hospital (5.4% to 6.6%) and the percentage distribution in the very-low-birth-weight (VLBW) groups (0.7% to 1.1%) varied somewhat from the five-year average of 6.03% (LBW) and 0.8% (VLBW). While the annual number of live births appears too small to allow statistically valid interpretation, the five-year total of 9,527 live births is sufficiently large to provide a statistically valid sample of VLBW patients when compared with vital records.

As an index of neonatal care, the VLBW mortality rate is particularly sensitive to distortion by the underreporting of deaths and selection bias.

The data here support the view that transferred-in newborns have a better prognosis in an NICU than newborns admitted from an attached in-house obstetrical service. At Deaconess Hospital 24.4% of all white neonatal deaths occurred within three hours post partum. The brief time these infants lived precluded, in all likelihood, their being transferred. Thus, it becomes apparent that nearly a quarter of neonatal deaths may not be considered in NICU statistics. The statistical forecast for transferred-in newborns improved

Table 1. — Distribution of 9,527 White Births by Weight (grams) at Deaconess Hospital, 1973 through 1977. Transfers from Nursery Included.

Weight gms	<500	501-750	751-1,000	1,001-1,250	1,251-1,500	1,501-2,000	2,001-2,500	<2,500	>2,500	Transfers
1973	1	4	4	5	0	18	67	99	1,718	2
1974	0	1	3	7	3	29	84	127	1,844	16
1975	1	5	1	3	6	18	99	133	1,881	16
1976	3	5	4	2	5	19	66	104	1,744	12
1977	0	4	5	5	3	25	70	112	1,765	17
Total	5	19	17	22	17	109	386	575	8,952	

Table 2.—Low Birth Weight Group Percentages
Compared to Data of Chase.⁸

Weight gms	< 500	501- 1,000	1,001- 1,500	1,501- 2,000	2,001- 2,500	< 2,500
% Low Birth Wt						
Deaconess Hospital	0.05	0.37	0.41	1.14	4.05	6.03
Chase (1974)	0.10	0.30	0.50	1.20	4.20	6.30

hourly after the second hour because of those deaths already recorded by the nursery of origin. Transfer candidates of low birth weight would have a more favorable outlook if it were the policy of nurseries to dispense with pediatric evaluations altogether and refer out all such newborns. As a practical matter some newborns would never be candidates for transfer. Parents may not want transfers, and the clinical implications of congenital anomalies, long periods of apnea, bradycardia, and neurological depression despite resuscitative measures might deter physicians from requesting transfers.

Although the practice has been questioned, VLBW-specific neonatal mortality rates are widely employed as an index of the quality of neonatal care.¹⁶ It is of the utmost importance to realize that selection bias may be greatest in the lowest birth-weight groups. At Deaconess Hospital 40% of newborns weighing < 1,000 g died within three hours and, apparently, the smaller the newborn, the sooner death occurred. Reports of LBW-specific neonatal mortality rates, in which inborn and outborn data were calculated separately, reveal that the outborn population is much more likely to survive than the inborn.^{3,5,17-19} Different sources of newborns may explain the conflicting conclusions in recently reported neonatal mortality rates in NICUs. The Jones study, which showed no improvement from 1960 to 1975 in mortality rates for neonates that weighed < 1,500 g, was based on inborns only.²⁰ Other reports, failing to separate inborn and outborn neonates contend that a marked lowering of mortality rates occurred.²¹⁻²⁵ Some of these improved rates, moreover, coincide with an increase in the number of newborns admitted for

treatment at NICUs, suggesting that the progressive improvements resulted because more outborn neonates were being included in the statistics.^{21,26,27}

Philip et al addressed the question of patient selection bias in NICU mortality rates.²⁸ Analyzing neonatal mortality rates in Vermont and New Hampshire (1976-1979), the au-

The time required to transfer infants during a period of high mortality risk is a crucial selective force.

thors concluded that the "trend is toward higher death rates in infant transfers." This conclusion is at variance with other cited reports and the data presented here.^{3,5,17-19} The Philip study demonstrated how large and how selective the attached obstetrical service of an NICU must be, in relation to the area served, before inborn and outborn death risks are roughly equalized. There were approximately 7,780 deliveries by a university obstetrical service, or 28% of all deliveries in Vermont during the time under study.²⁹ University deliveries were responsible for 64% of all NICU admissions. New Hampshire, which placed greater emphasis on maternal-fetal transfers, had only 2,400 deliveries during the same period at its university obstetrical service.²⁹ These deliveries accounted for only 4.9% of all state births but provided the NICU with 43% of its admissions.

Patient selection before delivery, therefore, creates another major source of referral bias that distorts neonatal mortality rates and may

spuriously improve them.³⁰ Paradoxically, patients selected and referred as high-risk maternal-fetal cases are more likely to decrease neonatal mortality rates in a referral center than those in a random obstetrical population. At Deaconess Hospital, 37 of 39 obstetrical charts were available for review for infants weighing 1,001 to 1,500 g at birth. All the cases had predelivery obstetrical care and a private physician responsible for the care. In this group, those women hospitalized less than one hour before delivery accounted for 9 of 19 deaths that occurred. Precipitate deliveries, with little or no time for referral, result in extremely high mortality, especially in the LBW groups.³¹ In Sweden, with 99% attendance at antenatal clinics, about one-half of the perinatal deaths occurred in previously uncomplicated pregnancies.³² The Scottish National Survey (1977) found that no maternal complications were associated with the commonest causes of perinatal deaths.³³ It appears that many, possibly most, VLBW neonatal deaths cannot presently be anticipated nor can the mother who will deliver a VLBW fatality be identified and treated as a high-risk maternity case.

... Transferred-in newborns have a better prognosis in an NICU than newborns admitted from an attached in-house obstetrical service.

Recent studies from NICUs have summarized and attempted to establish VLBW neonatal mortality rates for the seventies.^{28,34-36} All show similar rates, but patient selection factors, inflating survival rates, are present in all. As noted by Steiner, such data merely document what happened to those babies whose mothers wanted, agreed, or were obligated to have their babies at a referral center during or after birth.³⁷

The Philip study, reporting on predominantly white patients, shows survivals of 38% (501 to 1,000 g) and of 83% (1,001 to 1,500 g).²⁸ The authors combined hospital and state vital statistics, which introduced a source of unreported deaths in Vermont and underreported births and deaths in New Hampshire. They

also used English NICU statistics of inborns from high-risk referral maternity centers^{38,39} or mixtures of inborn and outborn patients (King's College).²⁴ The report from Denver was based on a 3.7% VLBW rate, explained partly by a large high-risk maternity population.⁴⁰ The Boston study, while reporting only on inborns, includes an extremely high number of infants weighing <1,000 g. These patients must derive from high-risk maternity cases or consist of large numbers of black newborns or a combination of both.^{41,42} Not all births in the Boston Hospital group are included in the data from the center's NICU.^{41,42} The Florida and Cleveland studies do not separate races, or inborns from outborns.^{21,25}

Budetti et al, in an extensive summary of VLBW-specific neonatal mortality rates, state that survival approaches 50% in the 1,000 g weight group and more than 80% survival in the 1,001 to 1,500 g weight group.³⁴ Only inborn cases are included; however, the authors fail to separate white and black mortality rates for the United States. Yet they state that "gram for gram black low-birth-weight newborns do better than white newborns of the same birth weight, although the reasons for this are unknown." This observation has been confirmed repeatedly by others.⁴³⁻⁴⁸ The Royal Victoria Hospital report excludes deaths from congenital malformation and includes antenatal referrals.¹⁰

Saigal³⁵ and Horwood,³⁶ recognizing the selective aspects in newborn and maternal-fetal referral systems, attempt to eliminate this bias by reporting on a geographically defined area with perinatal intensive care facilities. However, the survival rates (1973-1978) of 31% (501 to 999 g) and 82% (1,000 to 1,499 g) are similar to those reported by referral centers with large numbers of black newborns, outborn transfers, and attached high-risk maternity units. Available information indicates that not all births and deaths from the area are included. Admissions to the participating hospitals represent not all, but a selection of the patients from the area.

Canada had a VLBW rate of 7.8/1,000 live births in 1975⁴⁹; the Province of Ontario estimates they have 6.3/1,000 VLBW per year.⁵⁰ Total live-birth figures are not included, but Horwood reports that the VLBW rate (1973-1977) for the study area is 9.1/1,000.³⁶ During this period (1973-1977), 61% of live births (501 to 1,499 g) in the participating hospitals were from the area under study

(Hamilton-Wentworth region); 39% were from elsewhere.³⁰ If the same ratio prevailed for the following year (1978), approximately 22,894 of the stated 37,531 hospital live births would be from the Hamilton-Wentworth area, for a

It appears that many, possibly most, VLBW neonatal deaths cannot presently be anticipated.

VLBW rate of 12.8/1,000.³⁵ The conclusion must be that selection bias is present in the defined area studied. The bias simply is not as great as that occasioned by maternal-fetal transfers from outside the area.

As an index of neonatal care, the VLBW mortality rate is particularly sensitive to distortion by the underreporting of deaths and selection bias. The methodological problems creating these distortions of mortality rates have not yet been solved by reporting NICUs and their attached high-risk maternity services.⁶ Acceptable VLBW mortality rates, therefore, are lacking from these sources. The extent of the selection bias may be determined if the percent of VLBW infants treated at an NICU-high-risk maternity complex is compared to the percent of VLBW infants in the appropriate population at large. While national weight-specific mortality rates are not distorted by antenatal and postnatal transfers, and races are reported separately, no mortality rates are currently available.⁴⁸ The physician who treats newborns with a VLBW rate of 8/1,000 remains without weight-specific neonatal mortality rates to aid in a fundamental task in medicine, weighing therapeutic risks against therapeutic benefits.

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III: Management of Preterm Labor

MARY FRANCES BLOCK, MD

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Preterm delivery continues to exact its toll in perinatal morbidity and mortality, but newer therapy gives hope for arresting premature labor.

While the emotional, social, and financial impact of delivery of the infant who is significantly preterm is readily apparent, the causes of preterm delivery are often obscure. In some cases, premature delivery is preferable to the infant's remaining in a hostile intrauterine

environment, and delivery is planned. In most cases, however, delivery is not desirable, and attempts to recognize premature labor early and to intervene to prevent delivery are most appropriate.

Initial efforts to prevent preterm delivery must be directed toward recognition of those patients at particular risk for early birth. Table 1 lists epidemiologic correlates of prematurity gathered by the Obstetrical Statistical Cooperative.

The early diagnosis of premature labor is often difficult until progressive cervical dilatation has occurred. As a result, some patients may progress rapidly to an irreversible stage of labor, while others who are not in labor receive tocolytic agents and are exposed unnecessarily to their side effects. The clinician is required to differentiate true from false labor and preterm from term gestation, and to assess the relative risks of preterm parturition as compared to continued gestation.

While the differentiation of preterm labor and false labor is extremely inaccurate except in retrospect, guidelines suggested by several investigators include uterine contractions oc-

curring with a frequency of four per twenty minutes or eight in sixty minutes in the presence of ruptured membranes; or contractions of this frequency with intact membranes and cervical change, or effacement of 80%, or dilatation of 2 cm. While some patients' false labor may occasionally be misdiagnosed, the criteria are sufficiently liberal that few instances of premature labor should be missed.

If the diagnosis of preterm labor has been established, the next consideration is whether attempts to stop labor should be made. Table 2 lists contraindications for tocolysis.

General measures to prevent preterm parturition include adequate and appropriate

caloric intake and bed rest, although there are few prospective controlled studies to unequivocally establish efficiency of these measures.

Pharmacologic therapy to prevent premature delivery has expanded significantly in the past decade and is summarized in Table 3. The only FDA-approved tocolytic agent is ritodrine. An appreciation of the pharmacologic effects of the various tocolytic agents is necessary for the selection of an appropriate drug and dosage for each patient. For example, the use of ritodrine in the brittle diabetic is hazardous secondary to the increased difficulty of blood sugar control. Prostaglandin inhibitors are being used experimentally only because of the possibility of closure of the fetal ductus arteriosus.

The use of glucocorticoids for induction of fetal lung maturity has been proved effective by several clinical studies. In none of these studies were glucocorticoids one hundred percent effective in preventing hyaline membrane disease, and they have no effect on other problems of prematurity. Therefore, while helpful in the management of cases where tocolysis has failed, glucocorticoids are certainly not the final answer to problems of prematurity, and efforts must still be directed toward prevention of premature delivery.

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Table 1. — Epidemiologic Correlates of Prematurity

Maternal characteristics:

Nonwhite
Age < 15 yr
Low social class
Unmarried
Tobacco, alcohol, narcotic use.

Previous pregnancy performance:

Abortion and premature labor
Fetal and neonatal deaths
Placenta previa and abruptio placentae

Present pregnancy:

No prenatal care
Medical and surgical disease (anemia, heart disease, hyperthyroidism, diabetes, pyelonephritis, pulmonary disease, appendicitis, genital tract anomalies, chronic hypertension)
Pregnancy disorders
(pre-eclampsia/eclampsia, antepartum hemorrhage, multiple pregnancy, hyperemesis, congenital fetal anomalies, premature rupture of membranes)

Table 2. — Contraindications for Tocolysis

Relative	Absolute
Premature ruptured membranes Congenital anomalies Cervical dilatation of 4 cm or greater	Severe maternal disease— pre-eclampsia/eclampsia, heart disease Maternal hemorrhage Chorioamnionitis Fetal distress Fetal death

Table 3. — Tocolytic Agents

Type of Agent	Drug	Side Effects
Beta agonists	Isoxsuprine Terbutaline Ritodrine	Maternal and fetal tachycardia Maternal hypertension, arrhythmia, pulmonary edema, hypokalemia, hyperglycemia, hyperinsulinemia Neonatal hypocalcemia, hypoglycemia, ileus, hypotension
Alcohol	Ethyl alcohol	Maternal lactic acidosis and dehydration Newborn CNS depression Vomiting, aspiration
Magnesium	Magnesium sulfate	Maternal respiratory depression Neonatal hypermagnesemia
Prostaglandin inhibitors	Indomethacin	GI ulceration Possible premature closure of fetal ductus arteriosus and neonatal pulmonary hypertension

Report of the American Medical Association Council on Medical Service

REPORT D (A-83)

The Council on Medical Service of the American Medical Association presented the following report to the House of Delegates at its annual meeting with a request that it be disseminated for physician input. The council contends that the "usual, customary, and reasonable" payment system has been so distorted by third-party payors, including the government, that it no longer reflects the value of the services rendered by most physicians, and proposes an indemnity-based reimbursement system.

Physicians who wish to comment on the report should contact their AMA Delegate or Alternate, or send written comments to the OSMA headquarters.

INTRODUCTION

In the context of heightened concern about acceleration in health care spending, and with the exploration of alternatives to retrospective cost reimbursement for hospitals underway, increased attention is also being given by government, private payors, and the profession to the alternative methods under which payment can be made for physicians' services, and to the impact of each on the quality, accessibility, and costs of medical care.

In its Report K at the 1982 Interim Meeting, the Council alerted the House of Delegates to some of the problems for the profession seemingly resulting from use of the "UCR" [usual and customary or reasonable] concept to establish third-party physician payment levels, and further Council review of the entire subject of payment for physicians services was promised. The purpose of the present report is to convey to the House the findings to date of that review. Specifically, this report will address two major issues:

- I. Whether present Association policy on the general subject of payment for physician services continues to be appropriate in the context of the three basic approaches to such payment — fee-for-service, "capitation," and salary.
- II. Whether, with specific reference to the "fee-for-service" approach, current and future problems resulting from use of the UCR concept to establish the amount of third-party payment for physician services might be remedied by change to an indemnity-based system for such third-party payment. (Such indemnity payments would represent a schedule of allowances, and not a maximum fee schedule, with the physician charging the patient what he believes to be a fair and equitable fee.)

SYNOPSIS

Present Association policy, which supports freedom of patients to choose their source of care and freedom of physicians to choose their method of payment — including fee-for-service, capitation, or salary — continues to be appropriate.

Within the fee-for-service approach, current AMA policy supports the basing of third-party payment levels on the "usual and customary or reasonable" concept, and the majority of private and public payors use the "UCR" concept in establishing payment levels. However, the increasing costs resulting from this approach have caused both private and public payors to be caught between mounting pressure to constrain plan outlays on the one hand, and continuing consumer demand for comprehensive coverage of physicians' services on the other.

As one result, the "reasonable charge" used by payors — particularly public payors — in determining payment levels no longer reflects the actual charges made by most physicians because of infrequent updating of fee profiles, percentile cut-offs on customary charge data, and annual percentage caps on prevailing charge increases.

In addition, pressure is increasing on physicians to accept the payor-determined reasonable charge as payment in full (except for allowed deductibles or coinsurance) — ie, to become "participating physicians." Such pressure is exerted through:

- plan or company contracts which increasingly allow assignment of benefits or make payments only when services are provided by participating physicians;
- beneficiary misunderstanding of "explanation of benefit" letters and resulting patient/physician friction;
- "hold harmless" communications from payors to subscribers, and
- increased consideration nationally of mandatory assignment or fee schedules under Medicare.

As these trends continue, patients will be increasingly restricted to "participating" providers as a condition for insurance coverage. Eventually, physicians' remuneration will be determined solely by third-party payors for the great majority, if not all, of the professional services they render — with what the Council believes will be a resulting inevitable mediocrity in the quality of medical care.

Accordingly, the Council believes that the Association should seriously consider recommending that third-parties change to an indemnity system of payment for physicians' services, ie, paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis of claims experience, public demand, competition, and other relevant factors.

Such a change would benefit patients by:

- insuring their continued access to care not through external regulation of fees but through market forces;
- increasing both physicians' and patients' sensitivity to costs and quality of care provided;
- allowing them continued freedom of choice rather than being increasingly restricted to "participating" providers as a condition of coverage, and
- facilitating understanding and comparison of insurance coverages.

For third-parties, rate determination would be simpler under an indemnity approach. Payors could establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges. Administrative costs should be significantly less. For government programs especially it provides an alternative which permits budgetary restraints without further restrictions on type or duration of services covered or massive increases in enrollee co-payment.

... Unless there is a movement away from UCR reimbursement, medicine could become the captive of third-party payors.

For physicians this approach could bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third-party payment. Uncoupling third-party payment from physicians' charges could act to reduce legislative and political pressure for mandating physician "participation" as a condition of payment, and help preserve for physicians the freedom to charge what they believe to be a fair and equitable fee, subject only to normal and effective market constraints.

The Council believes that a change of this import in Association policy should be considered carefully by this House with their constituents over the next six months. The Council will also continue its study, and will submit recommendations at the 1983 Interim Meeting.

I. Is Present Association Policy On Basic Payment Mechanisms Appropriate?

There are essentially three ways in which a physician may be paid by patients, third parties and/or employers for his professional services:

- (1) on the basis of work done — or fee-for-service;
- (2) on the basis of patients enrolled — or capitation; and
- (3) on the basis of time spent — or salary.

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In *fee-for-service*, or payment on the basis of work done, the physician's income varies in proportion to the services he performs. The total cost of care is not derived from a flat rate per person or a contracted number of physician hours at a set rate per hour, but rather from patient demand and physician response in each individual care episode.

In the *capitation approach*, a physician (or the group with which he works) accepts a fixed amount from a patient, in return for providing that individual all needed medical services over a specified time period.

The *salary approach* is, of course, a "time spent" mechanism. It can be payment by the hour, day, week, month, or year — payment which is independent of how many patients are seen or what is done for them.

The literature attempting to identify the incentives on professional behavior exerted by each of these payment approaches — and their impact on quality, accessibility, and costs of care — is extensive, and the arguments advanced in support of each approach are well known.

Proponents of fee-for-service note that the control of expenditures in this system lies primarily with the patient and physician rather than with external parties, and argue that this lack of superimposed financial constraint allows the physician to be much more responsive to each patient's differing needs and demands. Detractors of this approach claim that this same flexibility creates incentives toward over-treatment, and that it is more difficult to predict and budget for total costs of medical care, both for the individual and the third-party payor.

Advocates of capitation claim that this approach contains built-in disincentives toward overutilization of services, encourages greater emphasis on preventive care, and tends to reduce the incidence of hospitalization and other high cost services. They add that costs of care are much more predictable under a capitation arrangement. Opponents tar capitation with the other side of the same "utilization" brush, arguing that it fosters *underutilization* of services in order to remain within budgetary constraints. They argue that, since payment depends on the number of patients enrolled, not on what is done for any one patient, the financial incentives act toward maximizing the patient list and minimizing the amount of service per patient, with a resulting tendency toward risk selection and reduced access for high risk patients.

Salary arrangements offer perhaps the most direct control over the amount of physician reimbursement. Such arrangements can be attractive to physicians by providing steady incomes at acceptable levels, facilitating a regular work schedule, and providing a full range of fringe benefits such as vacation time, pension plans, and professional liability coverage. A salary arrangement also may be more feasible for some underserved communities which might not be able to support a fee-for-service medi-

cal practice — as witness the National Health Service Corps. On the other hand, patient needs could tend to suffer due to the time constraints of the physician contract, and physician productivity could be adversely affected, increasing the total costs of physicians' services in the long run.

In the Council's opinion, a comprehensive reexamination and analysis of the arguments for and against each payment approach would serve no useful purpose in this report. Each of these three approaches has its own inherent strengths and limitations, and — while fee-for-service has continued to be the dominant mode of physician payment in this country — no one method has clearly demonstrated its superiority for all patients or is most suitable for all physicians.

Further, the Council would emphasize that the financial incentives exerted by payment mechanisms *are by no means the only or even the primary determinant of physician behavior*. All three payment methods discussed above have built-in financial incentives toward inappropriate treatment — over-treatment in one instance and undertreatment or indifferent treatment in the others. Yet the Council strongly believes that most fee-for-service practitioners are conscientious in their attempts to provide only needed services, most physicians in capitation-type programs do their best to provide high quality care to all their patients, and physicians paid on a time-spent basis often continue providing care after the time paid for runs out.

Because concern for patients' needs is the primary motivation in physician behavior, the patient is best served by having a variety of health care delivery and financing mechanisms from which to select the source of his or her care. It is the view of the Council, therefore, that present Association policy on this subject, which supports (a) freedom for physicians to choose the method of payment for their services, (b) freedom of patients to select their source of care, and (c) neutral public policy and fair market competition among all health care delivery and financing systems, continues to be appropriate.

II. Is Indemnity Preferable to UCR-Based Third-Party Payment?

The major source of physician payment under the fee-for-service approach has become the private or public third-party payor. In paying on a fee-for-service basis, such payors use one of two methods to establish the amount they will pay the physician or the patient for a particular service.

Under one method, variously termed a *benefit schedule* or *indemnity* payment system, the third party pays a set amount for a given service, which is determined by the payor on the basis of claims experience, negotiation with the insureds in some cases, and public demand. Schedules of this type are used in many Medicaid and workmen's compensation programs and traditionally by the majority of

commercial health insurance companies in their basic medical and surgical policies.

The alternate method for establishing the amount of third-party payment under fee-for-service is to base the payment in some way on what physicians in the area usually charge for similar services — the “usual and customary or reasonable” concept. This UCR approach is used in some form by the entire Medicare (part B) program, some of the Medicaid programs, most Blue Shield and other non-profit service plans, and most commercial insurance companies in their major medical and comprehensive policies.

Serious consideration should be given . . . to a change to an indemnity system of payment for the majority of services provided by physicians.

In its Report K (I-82), the Council identified some of the problems it perceived as resulting from UCR-based third party payment, and indicated its intention to review this subject in depth. The remainder of this report conveys the results of that review to date, including comments received from state and medical specialty societies on the subject since the Council's Report K (I-82) was submitted:

Existing Association Policy

Since 1965, it has been this Association's policy that the “usual and customary or reasonable charge” concept should be the basis for establishing both government and private third-party payments for physicians' services. The terms “usual,” “customary,” and “reasonable” were defined by the Association in 1968, as follows:

Usual is defined as the “usual” fee which is charged for a given service by an individual physician in his personal practice (ie, his own usual fee);

Customary is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socioeconomic area;

Reasonable is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question. (Resolution 48, C-68).

The inclusion of “reasonableness” as one of the three criteria for appropriate payment was intended to afford specific protection to the patient through

the availability of medical society review and sanction in those cases where a particular fee was not justified by the circumstances.

UCR-based payment was first adopted on a local experimental basis by the Wisconsin Physicians' Service (Blue Shield) in 1954, at the urging of physician members. It became a statewide program in 1957, and was soon followed by similar programs in Iowa and California. By the mid-1960s, a number of Blue Shield plans as well as a few commercial insurers were using this payment methodology, although a number of others were hesitant to offer UCR policies because of lack of actuarial history and experience in establishing fee profiles. From 1966 on, adoption of UCR-based payment progressed much more rapidly — partly because a type of UCR methodology was mandated by the Medicare law and regulations for setting physician payment levels under that program, and carriers were thus forced to develop the capability to administer such programs.

As originally conceived and implemented, linking third-party payment to physicians' actual charges offered a number of advantages to both physicians and patients; it enabled payor recognition of charge differences based on individual training, skills, and experience, as well as differences by area; allowed charges to reflect changing costs on a continuing basis; and assured patients access to covered services without undue economic hardship.

Focus of CMS Concern With UCR

However, as such comprehensive coverage became more widespread, a degree of insulation of both patient and physician from concern with health costs occurred. The subsequent escalation in health spending is now a matter of prime concern in public and private sectors alike. This concern has been intensified by the legal restraints now imposed against any attempt by the profession to help control health costs through fee review. As this House is well aware, under terms of the order issued by the Federal Trade Commission in May 1982, the AMA is prohibited from taking or espousing any action which would interfere with either the amount or the form of compensation provided a member in exchange for his or her professional services. The FTC order, together with court decisions holding that the use of peer review committees to determine the reasonableness of fees (Pireno, etc.) is not exempt from antitrust legislation, has had a chilling effect on professional fee review.

Caught between mounting pressure to constrain plan outlays on the one hand, and continuing consumer demand for comprehensive coverage of medical services on the other, public and private payors alike are reacting in ways which, in the Council's opinion, make it essential to reexamine Association policy in this regard.

Specifically, two major trends have become evident:

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- *Physician's vs Payor's Reasonable Charge* — the gap between the "reasonable charge" allowed by payors and the physician's actual charge is being widened;
- *Pressures Toward Participation* — pressures are increasing on physicians to accept the payors' version of the "reasonable charge" as payment in full — ie, to become "participating" physicians — and to not bill the patient any additional amount (except for allowed deductibles and coinsurance).

These important trends form the basis of the Council's belief that unless there is a movement away from UCR reimbursement, *medicine could become the captive of third-party payors.*

Physician vs Payor Reasonable Charge

The discrepancy between physicians' actual charges and those allowed under a "UCR-based" payment system is perhaps most striking in the Medicare program.

From the outset, Medicare's concept of "reasonable charge" differed from the profession's in several important respects. They differed, first, in definition. In contrast to Resolution 48 (C-68), Medicare defines a "reasonable charge" as the *lowest* of:

- (1) the actual charge made by the physician rendering the service;
- (2) the physician's "customary charge" for the service; or
- (3) the "prevailing charge" for the service in that locality.

The "customary charge" is defined by Medicare as the individual physician's median charge for the service, an amount which would cover his charge at least half the times he performed the service. The "prevailing charge" is essentially the amount which would cover the "customary charge" for the service in that area a *certain percent* (90%, 75%, etc) of the times it is performed. From enactment of Medicare until 1971, Medicare carriers were allowed to establish their own percentile cutoff for the prevailing charge — and set it as high as 90% in some areas. In 1971, the program changed from carrier-determined prevailing charges to a nationally-determined prevailing charge defined as the 75th percentile of customary charges for physicians of like training and skill, weighted by frequency, ie, an amount which would cover the "customary charge" for the service in that area at least three-fourths of the times it is performed. Physicians are then paid 80% of the Medicare-defined "reasonable charge" for covered services to beneficiaries.

Medicare's approach also differs from AMA's UCR concept in that the amount of Medicare payments

lags further behind current physician charges, since they are based on charge data up to two and one-half years old. Both the "customary charge" and the "prevailing charge" are calculated from data on physicians' charges during the calendar year before the fiscal year in which the claim is submitted; therefore, Medicare payments for most physicians' services are based on what the physician was charging a year to two and one-half years previously.

Finally, the two concepts differ in that, since 1976, the allowable yearly increase in Medicare payments is further limited by an "economic index" established by the Health Care Financing Administration. The "Economic Index" regulations of June 16, 1975, established a maximum percent of increase in "prevailing charges" allowable for any year over the prevailing charges in effect during fiscal year 1973. Thus, the allowed yearly percent of increase is limited not only by actual increases in physicians' charges but also by an economic index established by the Department of Health and Human Services, which is intended to reflect increases in the cost of doing business.

The index operates on the assumption that 40% of a physician's income goes to expenses and 60% to net income. It allows an expense-related increase in the prevailing charge based on data on salary increases in non-medical service industries, on increases in housing and transportation costs, on wholesale price increases for drugs and pharmaceuticals, and (for miscellaneous costs) on consumer price index increases. An increase in the net income component is allowed in proportion to increases in the earnings of production and non-supervisory workers, adjusted to eliminate productivity increases. The "economic index" is calculated annually by HCFA and furnished to all carriers.

These indemnity payments would represent a *schedule of allowances*, and *not* a maximum fee schedule.

Since its inception, the yearly increases in prevailing charges allowed by the index have been generally less than the overall inflation rate, thus progressively increasing the gap between physicians' charges and Medicare payment.

For fiscal year 1984, the Administration has recommended a one-year freeze on physicians' customary and prevailing fee levels — an even more stringent constraint on Medicare reimbursement amounts.

This progressively increasing discrepancy between physicians' costs and charges and Medicare payment* has been a major reason for the decrease

*Nationally, Medicare disallowed 19.5% of total physician charges submitted for Medicare beneficiaries in 1977 (the most recent year for which data are available).

in frequency of assigned Medicare claims since the program's inception. In 1969, physicians agreed to accept Medicare reimbursement as payment in full except for allowed deductibles and coinsurance in 61.5% of all claims; by 1980, that proportion had dropped to 51.5%. Most recently, 1982 year-end data from AMA's Socioeconomic Monitoring System indicate that the proportion of assigned Medicare claims has dropped to 42%. This same data indicates that 69% of physician respondents identified inadequate Medicare reimbursement as an important reason for their not accepting assignment.

The discrepancy between actual charges and third-party payment levels appears to be less across the other major source of UCR-based payment — the 69 Blue Shield plans presently in operation. According to Blue Cross/Blue Shield Association representatives, the majority of local plans use the 90th percentile, rather than the 75th as in Medicare, as the cutoff point for establishing prevailing charges. This may help account for the relatively high and stable rate of physician participation across those plans with participation agreements* reported by BC/BSA representatives — a rate averaging about 80%. However, two state medical societies did specifically communicate to the Council their concern with present or expected efforts by private payors to further restrict the amount payable under their "UCR" policies.

In addition, first quarter 1983 data from the AMA Socioeconomic Monitoring System indicate that 60% of those physicians electing not to enter into Blue Shield participation agreements in those areas where such agreements were offered did so because of insufficient reimbursement from the plan.

Pressures Toward "Participation"

Physicians are coming under increasing pressure to become "participating" providers — to accept the payor's version of the "reasonable charge" as payment in full and not bill the patient for any additional amount except allowed deductibles and/or coinsurance. Such pressure takes several forms.

1) Refusing assignment or payment to non-participating physicians.

Virgually all of the contracts written by Blue Shield plans with participation agreements will allow assignment of benefits to the physician by the subscriber *only* if the physician has entered that participation agreement, will accept plan reimbursement as payment-in full, and will refrain from "balance-billing" the patient. Non-participating physicians must recover their fee directly from the subscriber. As noted previously, Blue Cross/Blue Shield representatives expect most of the 10 local plans presently without participation agreements to

attempt to institute such arrangements shortly. The Council has been informed that Blue Shield is changing or planning a change to this approach in Arkansas, Indiana, and Ohio, and may be considering it in other states as well.

Blue Shield of Massachusetts and some plans in the state of Washington apparently have a more extreme form of participation agreement, *wherein no payment is made to either physician or patient for services performed by a non-participating physician*. The Massachusetts program has been under litigation by the Massachusetts Medical Society for the past four years. Other medical societies are considering litigation against their state plans. At issue is whether, among other questions, Blue Shield can unilaterally refuse to honor assignments by enrollees to non-participating physicians, or refuse payment entirely for services of such physicians.

Physicians are coming under increasing pressure to become "participating" providers — to accept the payor's version of the "reasonable charge" as payment in full . . .

A review of existing state legislation in this regard is informative. Statutory excerpts from relevant state laws relating to freedom of choice of provider, and to payment of such providers — for both medical service plans and commercial insurers — have been analyzed by the AMA Department of State Legislation.

According to that analysis, at least 32 states either allow or do not expressly prohibit non-profit service plans from issuing the above-noted contracts allowing assignment of benefits only to participating physicians. All states but one either allow or do not expressly prohibit such non-profit plans from making payment directly to subscribers for services of non-participating physicians. However, such plans are not as a rule *required* to make such direct payment to subscribers for services of non-participating physicians.

Stated another way, it would appear quite possible that, in many if not most states, applicable state legislation generally would not prohibit non-profit service plans from marketing contracts which would refuse payment *entirely* for service rendered by non-participating providers.

While commercial insurance companies are, on the whole, still subject to relatively stringent state prohibitions against any contractual restriction in the subscriber's freedom of choice, there appears to be relatively little statutory impediment to *non-profit medical service plans* in other states following the lead of those in Massachusetts and Washington.

* About 10 plans presently have no participation agreements with area physicians. According to BC/BSA representatives, this number is expected to decrease fairly rapidly over the next few years.

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2) *Misleading or inflammatory explanation of benefits to subscribers.*

The Council has for a number of years been attempting to obtain improvement of private and public third-party communications to policyholders which, in the profession's opinion, provide an inadequate explanation of the insurer's methods of determining the benefit payable for a service, and lead to patient misunderstanding.

The problem is especially severe currently in communications from private payors with UCR-based payment mechanisms, where the language used has often conveyed the implication that any fee greater than the amount paid by the insurer is, by definition, "unreasonable." Compounding this problem has been the continuation in some areas of communications from both medical service plans and commercial companies to their policyholders with UCR-type coverage, offering to defend policyholders in any legal action brought by a physician to recover the amount of his fee not covered under terms of the policy.

Strong concern with both of these problems — misleading "explanation of benefit" language and "hold harmless" communications — has been a recurring theme in medical society comments to the Council on this subject. Again, however, legal constraints hamper any organized professional effort to deal with these problems through discussions with private payors, assistance in fee review, or similar activities. Such constraints led the Council to conclude, in its most recent report to the House on this subject, that "solutions must be found that do not require the cooperation of the health insurance industry or the medical service plans" (CMS Report F, I-81).

3) *Mandatory assignment under Medicare.*

The past few years have seen increasing discussion in government sectors of the potential viability of legislation to mandate assignment as a condition of payment under Medicare: to require all physicians who treat Medicare patients to accept program reimbursement as payment in full, except for allowed deductibles and coinsurance; or to impose maximum fee schedules for services to beneficiaries. Such discussion will continue and further intensify as the present Administration seeks ways of paring a federal deficit now projected to reach \$267 billion in 1988.

A more recent and perhaps even more significant development has been the enactment of legislation in Congress calling for development of a DRG-based prospective pricing proposal for *physicians' services* in hospitals, as a part of proposals for prospective pricing of hospital services under Medicare. At the time this report was written, a final version of [a]

Medicare hospital payment program based on diagnosis related groups (DRGs) had been approved by Congress and sent to the President. One provision of the new law calls for HHS to report in 1985 on the "advisability and feasibility" of applying DRGs to physician charges for hospital services and of legislation to effect such a change. (A more complete description of this legislation appears in CMS Report A, also before the House at this meeting.)

THE FUTURE

If the trends and forces identified above continue to operate into the future, the Council can foresee only one logical outcome:

- If the acceleration in spending for health care continues to be fueled by the insulation of both physician and patient from cost concerns . . .
- If unions, consumer groups, and the public continue to press for comprehensive coverage of physicians' services . . .
- If payors continue to react by marketing more UCR-based policies requiring physicians' "participation" as a condition of payment — and consumers continue to purchase such coverage . . .
- If such mandated "participation" also becomes a part of the Medicare law . . .
- And if federal agencies continue to chill any professional attempts to deal with these problems through discussions and negotiation with payors . . .

Then medicine in effect will become the captive of public and private third-party payors — as they already have in a number of other countries — in that their level of remuneration will be determined solely by those payors for the vast majority, if not all, of the professional services they render — with the resulting inevitable mediocrity in the quality of medical care.

The Council has concluded, therefore, that this is the proper time to reevaluate the Association's policy that UCR be the basis for all third-party payments to physicians. The Council wishes to emphasize that this reevaluation applies *only* to the basis for third-party payment, not to the more basic issue of how the individual physician in his own practice should establish his fees.

After substantial and in-depth consideration, the Council is of the opinion that serious consideration should be given by all third-party payors, government and private, to a change to *an indemnity system of payment for the majority of services provided by physicians*, ie, paying a set amount for services rather than some proportion of the "usual and customary or reasonable" charge. Such a set amount would be determined by the payor itself on the basis

of claims experience, public demand, negotiation with insureds, and other relevant factors. As noted previously, these indemnity payments would represent a *schedule of allowances*, and not a maximum fee schedule; the physician would continue to be free to charge the patient what he believes to be a fair and equitable fee for his services.

The Council believes that such a change will be to the immediate and long-term advantage of patients, third parties, and physicians.

For patients, it will assure continued access to care not through external regulation of fees, but through the more effective mechanism of the marketplace, by increasing both physicians' and patients' cost-awareness. The fee will again become the business of the physician and patient, with increased sensitivity by both to the quality and costs of care provided. This could, in fact, become an important "consumer choice" approach, since the patient will have a more substantial incentive to seek a physician whose fees are reasonably related both to patient satisfaction with care and to the amount Medicare or his or her private insurance pays, and to explore the reasons for differences in physicians' charges. It will allow patients continued freedom to seek the best in medical care, rather than being increasingly restricted to "participating" providers as a condition for insurance coverage. For those in the market for private insurance coverage, it will be much easier to understand and compare extent of insurance coverages — another "consumer choice" goal this Association has long supported. For Medicare beneficiaries as well, selection of supplementary private insurance plans tailored more precisely to Medicare coverage "gaps" will be simplified.

A contractual relationship would exist only between payor and subscriber, not between payor and physician.

For third parties, rate determination is simpler under an indemnity approach; payors can establish premiums on the basis of prospective analysis of what the plan pays rather than on a statistical array of physician charges; administrative costs should be significantly less. For government programs especially, it provides an alternative which permits more precise budgetary forecasting without further restrictions on type or duration of services covered or massive increases in enrollee copayments. For programs such as Medicare and national private health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to ensure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For

Medicare, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

For the profession, the Council believes that this approach can bring improved patient-physician interaction, since neither physician nor patient will have false expectations of the amount of third-party payment. *Uncoupling third-party payment from physicians' charges will reduce legislative and political pressures for mandating physician "participation" as a condition of payment (which in effect would constitute a maximum fee schedule) and help preserve for the profession the continued freedom to charge what they believe to be a fair and equitable fee, subject to the normal and effective constraints of the market.*

The only exception to use of an indemnity-based approach to payment levels would be in the type of "catastrophic" coverage offered under both private and public payor programs where no further coinsurance or copayment is imposed once the beneficiary has spent a specified amount out-of-pocket. In order for such catastrophic coverage to provide meaningful protection to beneficiaries on the one hand and offer some degree of cost predictability to payors on the other, both the amount of patient spending allowed to count toward meeting the out-of-pocket spending limit and the amount of third-party payments in the catastrophic portion of their plans should continue to be related in some way to the actual charges of physicians. To illustrate, if the plan were paying for physicians' services on an indemnity basis, the entire difference between the indemnity payment and an individual physician's actual charge — no matter how high — could, theoretically, be applied toward meeting the catastrophic threshold. In the Council's view, it would be more appropriate to allow only the difference between the indemnity payment and physicians' customary charges (or a certain percentile thereof) in the area to count toward the catastrophic threshold.

By the same token, once the catastrophic threshold is reached, most insurance plans currently do not pay *all* additional expenses incurred for covered physicians' services, but rather at a percentile of physicians' customary charges for these services, but without imposing coinsurance on the beneficiary. If a plan paid on a flat indemnity basis above the catastrophic threshold, some patients could continue to have major out-of-pocket expenditures for physicians' services. On the other hand, payment for *all* costs of physician services above the catastrophic threshold could be extremely expensive for the plan. Accordingly, the Council believes it would be desirable for payors to continue to relate their payment for physicians' services to physicians' customary charges in the catastrophic portion of their plans.

The Council recognizes that such a change to indemnity-based third-party payment for most ser-

AMA REPORT

vices provided by physicians represents a significant departure from past AMA policy. This is especially true in light of the fact that the UCR method of health insurance payment for physician services began with a major thrust from the sponsorship of state medical associations and, later, of this Association. However, as health insurance has grown, it has also become a strong and independent entity.

In the past decade, the AMA has given formal recognition to that independence by first, in 1976, discontinuing appointment of members to the national Blue Shield Association Board, and, second, by establishing the policy that the Association should avoid supporting a competitive advantage to any one type of health insurance company.

The Council believes this principle has served the Association well, and believes that the recommendation it makes here is a valid and appropriate extension of that policy. Further, the Council is of the opinion that the recommendation of indemnity-type payment methods makes even clearer the Association's determination that such third parties are and will remain separate and distinct from organized medicine, serving the patient rather than the physician.

This approach will not preclude the Council's continuing to meet with representatives of both the Blue Shield plans and the Health Insurance Association of America in efforts to improve the cost-effectiveness of medical care and in such pro bono publico efforts as the promotion of community health care coalitions.

The Council recognizes that this recommendation is one which third-party payors may not choose to implement at once. For the service plans in particular, such a change represents a major shift in their approach to coverage for basic health expenses. However, the Council believes that in the long run it will not only be to the advantage of such payors, but that it leads the nation in the appropriate direction.

The Council also believes that a change of this import in Association policy should not be made precipitously, but that members of this House, and the Federation as a whole, should carefully evaluate for themselves the arguments for such a change before taking action.

Recommendation:

The Council recommends, therefore, that members of the House consider this issue with their constituents and other concerned parties over the next six months, communicate any additional views and comments to the Council, and come to the next Interim Meeting of this Association prepared to further express their views on the subject.

State medical society communications to the

Council indicate that such consideration is already underway in some areas. One state association has recently changed its policy to one of support for an indemnity-based system and two others indicated that such a change has been or is being considered.

The Council will also continue its study of the subject, and will submit recommendations to the House at the 1983 Interim Meeting. To illustrate the range of issues that may merit attention by the Federation, five examples of the types of questions the Council has addressed in its study, along with the Council's conclusions, are appended to this report.

Appendix

Questions Regarding UCR and Indemnity

Question

If private and public payors were to change to paying for physicians' services on an indemnity basis, what would prevent such payors from then requiring physician acceptance of the *indemnity amount* as payment in full — in effect, converting such indemnity payment to a maximum fee schedule?

Answer

For the Medicare program, first, requiring all physicians who treat Medicare patients to accept program reimbursement (whether a "UCR"- or indemnity-based amount) as payment in full would require a change in the Medicare law. From the program's

The patient is best served by having a variety of health care delivery and financing mechanisms from which to select.

point of view, uncoupling payment levels from physicians' actual charges would reduce the need for such legislative change, since it would eliminate the continuing cost push on program spending exerted by UCR-based payment, and allow much more predictable budgeting. It is true that, if Medicare changed to an indemnity basis, beneficiaries would probably exert political pressure to prohibit balance billing by physicians. *However, they are already exerting such pressure because of the growing discrepancy between Medicare's "reasonable charge" and physicians' actual charges.* In the Council's opinion, the only net political effect of changing Medicare to an indemnity basis would be to eliminate one of the important "justifications" advanced for such mandated assignment and ban on balance-billing — the assertion that "our payment is based on what most physicians charge anyway."

With regard to private payors, it should be remembered that what the Council is suggesting is a change to *indemnifying the patient* against health

care expense; a contractual relationship would exist only between payor and subscriber, not between payor and physician. It could be a violation of the antitrust laws for service plans and commercial companies to market an indemnity plan which would pay only when the physician accepted the indemnity amount as full payment. As a practical matter, too, it would be difficult for such plans to survive in a competition market, *since they could offer no assurance to subscribers of any reasonable level of access to covered services – that is, few physicians would be likely to commit themselves to accepting as full payment an amount no longer contractually tied to actual charging patterns.*

Question

Since unions and consumer groups have exhibited a strong and continuing preference for comprehensive, service-type benefits, will changing to an indemnity system drive more of them out of the fee-for-service sector and into alternative, capitation-type systems?

Answer

It is probable that the premiums for coverage under capitation-type systems will be generally *higher* than those for indemnity coverage under traditional insurance plans. A recent study by the Congressional Budget Office indicates that the average premium for HMO family coverage *now* is higher than that for traditional health insurance plans (\$132/month for HMO coverage vs \$104/month for all employment-based insurance). The tax law and other changes in the six AMA "consumer choice" principles presently supported by AMA would reduce the attractiveness of such more expensive coverage.

Even if premiums for the two types of coverage were comparable, a further shift to capitation-type programs should occur only to the degree that traditional systems are unable to compete on the basis of *either* price, or quality/accessibility. But if traditional fee-for-service medicine offers a better product, patients will still be willing to pay more for it.

Question

If private and public payor levels are uncoupled from physicians' actual charges in an area, how would regional differences in cost be allowed for? In addition, would inflation act over time to make the indemnity allowances increasingly inadequate?

Answer

For programs such as Medicare and national private

health insurance accounts, the indemnity amounts could vary from one region to another based on cost-of-living differences. Market forces would act to ensure that the indemnity amounts under private plans would be set at a reasonable and competitive level, and increased as economic conditions dictated. For Medicare, consumer and professional groups alike could continue their advocacy for reasonable and economy-indexed increases in indemnity payment levels, as they do now under the present reimbursement approach.

Question

If the Medicare program paid for physicians' services on an indemnity basis, how would this affect Medicaid?

Answer

A physician who treats a Medicaid patient and bills for his services is already required by law to accept the amount of the state agency's reimbursement as payment in full. Almost half the programs now pay on the basis of a fee schedule set by the state agency. Those states where payment is now the same as or a percentage of Medicare rates would have the option of establishing their own fee schedule or of keying payment to Medicare's new indemnity levels. To forestall even further reduction in access to care for beneficiaries in these latter states, consumer and professional groups would need to continue and perhaps intensify their advocacy for reasonable Medicaid payment levels.

Question

Will the majority of physicians in fact be willing to now deal solely with the patient in fee matters, or will they continue to prefer to accept a lesser but "guaranteed" payment from the third party?

Answer

The Council believes this is a key question. The Council further believes that the majority of physicians will choose to make this change, if they perceive clearly the long-term adverse consequences of not doing so.

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4. Results on Special Topics Questions, SMS 4th Quarter 1982 Survey.



News From The Oklahoma State Department of Health

Breast Brochure Available

A brochure now available from the Oklahoma State Department of Health is designed to answer some of the overwhelming questions facing a woman who has found a lump in her breast and to provide assistance in making informed decisions regarding treatment options.

"Alternatives: A Discussion of Breast Cancer Treatments" outlines a number of methods used by physicians to determine if a breast lump is malignant, including mammography and biopsy. The brochure explains the differences between one-step and two-step surgical biopsies — the most significant difference being that the two-step allows for treatment to be performed at a later date, should a biopsy indicate the tumor is malignant.

The brochure also explains the factors considered in determining appropriate breast cancer treatment and the treatment options available, allowing a woman to work with her physician in deciding which treatment is best for her.

Finally, the brochure has a tear-off card listing 10 questions a woman should ask her physician concerning procedures used, treatments, etc.

The brochure is free and can be obtained from the health department by calling or writing the Film and Publication Distribution Center, Oklahoma State Department of Health, PO Box 53551, Oklahoma City, OK 73152, phone (405) 271-5188, or by calling the Oklahoma Cancer Information Line, 1-800-522-0220 (OKC metropolitan area, 271-8181). □

COMMUNICABLE DISEASES IN OKLAHOMA FOR JULY 1983

DISEASE	JULY 1983	JULY 1982	JUNE 1983	TOTAL TO DATE	
				1983	1982
Amebiasis	—	—	—	4	9
Aseptic Meningitis	96	29	39	183	66
Brucellosis	1	—	—	4	4
Encephalitis, Infectious	8	3	2	19	16
Gonorrhea (Use Form ODH-228)	1,171	1,527	1,451	8,996	9,257
Hepatitis A	51	87	45	284	420
Hepatitis B	34	39	35	181	189
Hepatitis, Unspecified	28	32	12	146	155
Malaria	—	3	1	7	6
Measles (Rubeola)	—	—	—	1	—
Meningococcal Infections	3	6	4	26	22
Pertussis	61	—	36	131	3
Rabies (Animal)	9	17	14	83	132
Rocky Mountain Spotted Fever	86	26	45	161	67
Rubella	—	—	—	—	3
Salmonellosis	72	58	56	292	186
Shigellosis	23	49	13	109	185
Syphilis (Use Form ODH-228)	16	26	14	143	118
Tetanus	—	—	—	—	1
Tuberculosis	—	25	1	126	234
Tularemia	6	8	6	18	19
Typhoid Fever	2	—	—	3	2

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Physician Becomes Third Oklahoman Elected to Institute of Medicine

C.S. Lewis, Jr, MD, well-known Tulsa internist, has been elected to membership in the national Institute of Medicine, Washington, DC. He becomes the third Oklahoman to be so honored.



The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of medical and other professions for the examination of policy matters pertaining to the health of the public. New members are elected by present active members from among candidates chosen for major contributions to health and medicine, or such related fields as the social and behavioral sciences.

Members make a commitment to devote a significant amount of time to work on committees engaged in a broad range of health-policy issues.

Dr Lewis is one of 36 new members who will begin their terms January 1. Their election brings the total active membership to 456.

Lewis earned his medical degree in 1945 at the Washington University School of Medicine, St Louis. He established his private practice in Tulsa in 1951 and has been involved in numerous professional activities since then. Currently a clinical professor at the University of Oklahoma College of Medicine and a member of the board of directors at St John's Hospital in Tulsa, he is a past president of the Oklahoma State Medical Association (1977-1978) and a past president of the Tulsa County Medical Society.

The Muskogee native was actively involved in the establishment of the Tulsa branch of the University of Oklahoma College of Medicine and has served as a faculty member since its

founding. He has also been on the board of directors of the Oklahoma Foundation for Peer Review and served as chairman for the Oklahoma Physician Manpower Training Commission. □

Chelation Therapy Not Effective As A Treatment for Atherosclerosis

Chelation therapy with edetic acid or its sodium salt is not an established treatment for atherosclerotic vascular disease, according to a recently released evaluation by the Diagnostic and Therapeutic Technology Assessment (DATTA) service of the American Medical Association.

Chelation therapy has been gaining popularity as a treatment for atherosclerotic vascular disease and other diseases. The contention is that repeated intravenous infusions of the chelating agent edetate disodium is of benefit to patients with coronary artery disease. According to the DATTA report, however, the treatment has not been proven in any "well-designed, controlled trial."

The report also notes that the Department of Health and Human Services and other agencies question the rationale and safety of the procedure.

The DATTA program relies on a roster of 483 physicians from which panels of at least 20 specialists are assigned to study a given question. Panel responses are based on a consensus of those panelists.

The DATTA program was begun last year as a result of a long-standing AMA interest in the assessment of new medical knowledge and technologies. □

Children of Alcoholics May Face Inherited Sensitivity to Alcohol

Children of alcoholic parents may face a genetically determined increase in their risk of developing alcoholism, according to an international study.

Vicki E. Pollock, MA, from the University of Southern California, Los Angeles, and colleagues in New York and Copenhagen found differences in brain wave responses between control subjects and the biological sons of alcoholic fathers after a single low dose of alcohol. Reporting in the August issue of *Archives of General Psychiatry*, the researchers suggest that these children may be particularly sensitive to the effects of alcohol.

Pollock says that the EEG changes that occur after the subjects drink alcohol may be biologic markers for genetic central nervous system sensitivity to alcohol. Citing the work of other investigators, she points out that the greater similarity of EEG response to alcohol between identical twins when compared to that between fraternal twins further supports her thesis.

Evidence indicates genetic influences on the rate at which the body metabolizes alcohol, Pollock continues, though her study showed no differences between high risk men and controls in blood alcohol levels, a measure of alcohol metabolism.

All subjects had been informed that they were drinking alcohol. Pollock theorizes that the high risk men, with their experience of living with an alcoholic parent, may have differed from the controls in their expectations about the effects of alcohol, and this in turn might have affected their EEG responses.

The study included 48 Danish men aged 19 to 21 years. Thirty-one of them had alcoholic fathers and were considered the high risk group; 17 served as controls. After drinking a mildly alcoholic test beverage, the young men underwent electroencephalography (EEG) and measurement of blood alcohol concentration.

There were significantly greater increases of slow alpha energy in the high risk group, as well as decreases in fast alpha energy and mean alpha frequency. There was no significant difference in blood alcohol levels.

Questioned about their drinking habits prior to the study, the high risk group reported requiring more alcohol (average 3.4 drinks) than



At the Tulsa Hilton Inn Dr Ed Calhoon (right) admires the A. H. Robins Community Service Award received by Floyd F. Miller, MD, as Miller's wife Adeline and son look on. Dr Calhoon presented the award to Dr Miller at the OSMA Board of Trustees meeting.

the controls (average 2.8 drinks) to feel "tipsy."

In a separate interview, Pollock said that the researchers could not speculate on the apparent discrepancy between the high risk group's subjectively lower sensitivity to alcohol and the higher sensitivity suggested by the laboratory findings.

She emphasized the preliminary nature of the data and pointed out that the study included no placebo controls. □

Honors Bestowed at Board Meeting

Three individuals were given special recognition at the August meeting of the OSMA Board of Trustees in Tulsa.

The 1983 A.H. Robins Community Service Award was presented to Floyd F. Miller, MD, of Tulsa, by Ed L. Calhoon, MD, Beaver, in recognition of Dr Miller's outstanding community service. Sidney J. Sartain, professional relations manager for A.H. Robins, attended as the Robins representative.

Dr Miller is a past president of the OSMA (1980-1981) and a former president of the Tulsa County Medical Society. He is also a former president of the Oklahoma Society of Internal Medicine and of the Oklahoma Allergy Society, and has served as a member of the House of Delegates of the American Society of Internal Medicine.

Honorary OSMA memberships were awarded to Don Blair, executive vice-president of PLICO and former OSMA executive director, and Wilson D. Steen, PhD, head of the Division of Community Medicine, Department of Family Medicine at the University of Oklahoma Health Sciences Center. George H. Kamp, MD, OSMA president, presented certificates to Blair and Steen "in recognition of distinguished service to medicine."

Don Blair served as executive director of the OSMA for 17 years before resigning in 1976 to join C.L. Frates and Company in an executive position overseeing insurance programs for the OSMA, the Oklahoma Hospital Association, and the Oklahoma Osteopathic Association.

Dr Steen, in addition to his active involvement in student affairs at the medical school, serves as faculty coordinator for the OSMA student communication program. □

Don Blair, executive vice-president of PLICO and former executive director of the OSMA, accepts honorary OSMA membership.



Thanking the OSMA board of trustees for his honorary membership is Wilson D. Steen, PhD, head of OUHSC's Division of Community Medicine.

(Photos by Anita Delaporte)





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PLICO Health Being Offered With No Proof of Insurability Required

Fall marks the launching of a major sales effort by PLICO Health, announced PLICO president Dr C. Alton Brown recently. If all goes as planned, the health insurance arm of the Physicians Liability Insurance Company will be helping at least 1,000 additional doctors' clinics shave 30% to 40% off their health insurance costs.

No proof of insurability will be required during the sales campaign.

"We have a truly great health care financing program which offers unlimited benefit horizons at premium rates well under the top-of-the-line policies sold by our competitors," said Brown. "The doctors, their employees, and their respective dependents who now have PLICO Health — some 15,000 in number — are collectively saving about \$3,000,000 annually," he continued.

Dr Brown expressed confidence that the sales effort will be successful.

"In the beginning, some physicians undoubtedly held back to see how PLICO liked the

health insurance business. The answer is we're very comfortable with it, and I want to emphasize that we are into this insurance business to stay," Brown said.

PLICO Health's monthly premium ranges from \$54 to \$67 for an individual and from \$108 to \$134 for a family, depending on the annual deductible selected.

A dental care option can be added to the PLICO Health coverage, and a Medicare Supplement policy offers lower rates and greater benefits than other such programs available in the state.

While the policy decisions governing the health insurance plan are ultimately made by the full PLICO Board of Directors, all decisions are based on the evaluations and recommendations of a special PLICO Health Committee chaired by Eugene G. Feild, MD, PLICO board member from Tulsa. Serving with Dr Feild are Drs Billy G. Goetzinger, Oklahoma City; Ray V. McIntyre, Kingfisher; John R. Alexander and Floyd F. Miller, Tulsa; and Kenneth W. Whittington, Bethany — all members of the PLICO board. Also serving on the committee is A. Wayne Coventon, representing the Oklahoma Clinic Managers Association.

Physicians and clinic managers who would like more information on PLICO Health are urged to phone the PLICO Health Sales and Service Department at (405) 843-0215. □

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Great Smokeout Almost Here

The Great American Smokeout will take place November 17. On that day, the American Cancer Society will ask smokers across the country to kick the habit for 24 hours.

In 1982, just over 19 million American smokers attempted to give up cigarettes on Smokeout Day. According to a survey conducted by the Gallup organization, 4.5 million succeeded for a full 24 hours. One to eleven days later, 2.3 million reported still not smoking.

An "Adopt-A-Smoker" program will be initiated this year to get nonsmokers involved in the activities. "Adoption papers" will be given to nonsmokers who want to help a friend "on the path of smokelessness."

Plans are being made now for Oklahoma's Smokeout. If you'd like to be involved, contact your American Cancer Society. □



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Board Cautions Against Excess Use Of Emergency Room Referrals

In a resolution adopted at its August 14 meeting, the Board of Trustees of the Oklahoma State Medical Association (OSMA) once again asked its member physicians to avoid excessive referral of patients to hospital emergency rooms.

The resolution reaffirms the association's position on physician referral in discouraging the practice of "checking out" to the emergency room. Physicians are encouraged to have a back-up physician available to patients who call about emergencies when the regular physician is not available.

Studies and surveys have confirmed that people often use hospital emergency rooms for treatment of non-emergency illnesses. Such overuse of emergency rooms contributes unnecessarily to high medical costs for patients, as does the routine referral of patients to emergency rooms when physicians are out of their offices.

Doctors statewide are urged to comply with the resolution. □

Kidney Transplantation Improves, Raises Questions About Recipients

A study recently published in the *Journal of the American Medical Association (JAMA)* reports increasing survival rates in recipients of kidney transplants, complicating decisions about who should receive transplants.

Contrary to previous reports, patients who reject kidney transplants are not at increased risk when returned to hemodialysis, say Arthur J. Mates, MD, and colleagues from the Montefiore Medical Center-Albert Einstein College of Medicine in New York.

Their study compares the survival of patients returned to hemodialysis after losing a kidney transplant with the survival of patients undergoing maintenance hemodialysis during the same period as reported by dialysis centers in the United States and Europe.

In editorial comment on the study, Christopher R. Blagg, MD, of the Northwest Kidney Center in Seattle says that the improved results of transplantation in recent years raise several questions that should be addressed.

"How many patients undergoing dialysis

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are, in fact, candidates for transplantation?" he asks. "The mean age of patients starting dialysis is now in the middle 50s, yet many consider this to be the upper age limit for transplantation."

Blagg also raises the question of the efficacy of transplantation. "Transplant recipients, although their age may range into the 50s, are most frequently selected from patients undergoing dialysis who are younger than 45 years, so unless age-matched survival and rehabilitation data are available for medically comparable patients, it is not possible to compare survival rates between the two treatments." □

Tulsans to Head Oklahoma Affiliate Of American Diabetes Association

Two Tulsans have been elected to head the newly reorganized state chapter of the American Diabetes Association. Don Wilson, MD, is the new board chairman and James T. Hirlinger is the new president and chief operating officer of the merged Eastern and Western Oklahoma chapters.

New officers from Oklahoma City are Piers Blackett, MD, chairman-elect and John Holcomb, MD, secretary.

Other officers elected are Leonard Kindred, vice-president of fund raising, and Mike Camp, CPA, treasurer, both of Tulsa.

The chapter consolidation was approved at the group's recent meeting in San Antonio. Programs and services for the entire state will now be directed from the Association offices in Tulsa; regional offices will be open in Oklahoma City, and chapter offices throughout the state.

The Tulsa office, 6565 South Yale, will coordinate public, patient, and professional education and research activities for more than 150,000 Oklahoma diabetics and their families.

The office will be open from 9 AM to 5 PM

Monday through Friday. The Tulsa number is (918) 492-4047 and the toll free number is 1-800-722-5448. □

Out-of-State Directory Solicitation Warrants Second Look by Physicians

The U.S. Directory Service in Miami, Florida, is currently soliciting listings from state physicians for its *U.S. Medical Directory*. A "listing fee" of \$35 is being charged.

Doctors should be aware that the publication has not been approved or sanctioned by the Oklahoma State Medical Association (OSMA), the American Medical Association, or any leading physician organization.

The recognized directories for physicians are the county medical societies' directories, the OSMA directory, and the AMA directory.

The 1983 edition of the OSMA directory becomes available this month. Each OSMA member will receive one copy free of charge and may buy a second copy for \$12.50. Non-members may purchase a copy for \$17.50. □

Physicians Named Life Members By OSMA Board of Trustees

Eleven Oklahoma physicians were elected to OSMA Life Membership at the OSMA Board of Trustees meeting in May, and two were named at the August meeting.

Approved for lifetime membership at the May 4 meeting were James K. Boyd, MD, Tulsa; Jesse S. Chandler, MD, and Gilbert W. Tracy, MD, Muskogee; B.C. Chatham, MD, Chickasha; Edward T. Cook, Jr, MD, Anadarko; William M. Haynes, MD, Henryetta; William J. Dowling, MD, and William E. Jones, Jr, MD, Bristow; and E.C. Lindley, MD, E.H. Lindley, MD, and Robert H. Mayes, MD, Duncan.

Approved at the August 14 meeting were R.R. Coates, MD, Chickasha, and Charles W. Freeman, MD, Oklahoma City.

To be eligible for OSMA Life Membership, a physician must be a member in good standing of the association and must meet one or more of the following criteria: be retired from the active practice of medicine because of ill health or age; be engaged in the active practice of medicine for 50 or more years; be 70 years of age. □

Erratum: In the September issue of the *Journal* the name of the advertiser on page x, **Staff Leasing, Inc.**, was inadvertently omitted by the printer. The *Journal* regrets the error and extends its apologies to Staff Leasing, Inc.

Book Review

Principles of Ambulatory Medicine. Edited by L. Randol Barker, John R. Burton, and Philip D. Zieve. Baltimore and London: Williams & Wilkins, 1982. 1,127 pages. \$65.00.

In the preface of *Principles of Ambulatory Medicine* the editors state that this book is directed "primarily to the general physician who cares for ambulatory adult patients." For this audience, 63 contributing authors having professional affiliation with Baltimore City Hospitals and the Johns Hopkins School of Medicine have developed a comprehensive text which does indeed focus upon the problems of concern to the physician.

The book begins with a section of eight chapters that briefly address some of the general features of ambulatory health care, preventive and occupational medicine, disability and rehabilitative issues, and some of the unique fea-

tures of adolescent and geriatric medicine. The major content of the text is divided into ten sections and 74 chapters which follow a more traditional "systemic" organizational approach. The final four sections deal with some of the common surgical problems, gynecologic disorders, disorders of the eyes and ears, and some of the common dermatologic and dental problems that the physician is likely to encounter in practice.

The text is well written, easy to read and follow, and is liberally supplemented with useful charts, tables, and graphs. Its approach is quite pragmatic and, while emphasizing the recognition and management of common or important disorders, special attention is given to the recognition of those patients having problems that should be referred for specialized care. Where data are available, the authors have included probability information relative to diseases, populations, and treatment regimens for use by the physician as patient management is considered. Each chapter closes with a brief list of annotated general references and a somewhat more inclusive set of specific references for the reader who desires additional information.



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Although this text certainly has neither the breadth nor depth of some of the traditional encyclopedic texts in internal medicine and other disciplines, the editors have not intended it to be competitive with any of the specialty texts; it is multidisciplinary in scope. I would suggest that the editors broaden, beyond the "generalist" specified in the preface, the list of those physicians for whom this could be a valuable reference. Any family physician, emergency physician, general surgeon, inter-

nist (and many subspecialists), or gynecologist could benefit from reading this volume. It addresses common problems in the practice of adult medicine in a very useful way and contains many practical "pearls" for every physician who cares for adult patients in an ambulatory setting. This book can be highly recommended.

James H. Schmidt, MD
University of Oklahoma Health Sciences Center
Oklahoma City, Oklahoma

Deaths

EDWARD A. ALLGOOD, MD 1919 - 1983

Edward A. Allgood, MD, longtime family practitioner in Snyder, died August 18 in Sulphur. Dr Allgood was born in Altus in 1919 and graduated from the University of Oklahoma College of Medicine in 1945. After serving two years in the US Army, he established his practice in Snyder in 1948 and remained there until his retirement in 1980. Dr Allgood was a Diplomate of the American Board of Family Physicians and had received the Physicians Recognition Award from the American Medical Association. He was also a fellow of the American Academy of Family Physicians.

HUGH E. WILSON III, MD 1924 - 1983

Hugh E. Wilson III, MD, medical director of St Anthony Hospital in Oklahoma City, died August 27. A cardiovascular and thoracic surgeon, Wilson practiced in Dallas and in Puerto Rico before moving to Oklahoma in 1981. He was born in Auburn, Alabama, and graduated from the University of Michigan Medical School in 1948; he served in the US Navy during the Korean conflict. Wilson was a member of the American College of Surgeons, American College of Chest Physicians, American Thoracic Society, American College of Cardiology, Society of Thoracic Surgeons, and American Association for Thoracic Surgery.

In Memoriam

1982

<i>William A. Eastland, MD</i>	<i>October 3</i>
<i>William J. Craig, MD</i>	<i>October 19</i>
<i>William M. Wood, MD</i>	<i>October 30</i>
<i>Hugh C. Graham, Sr, MD</i>	<i>November 11</i>
<i>John David Wilson, MD</i>	<i>November 11</i>
<i>Clinton Gallaher, MD</i>	<i>November 15</i>
<i>Bert F. Keltz, MD</i>	<i>November 30</i>
<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

<i>Dewey K. Rhea, MD</i>	<i>January 3</i>
<i>Fred C. Buffington, MD</i>	<i>January 4</i>
<i>C.D. Cunningham, MD</i>	<i>January 26</i>
<i>William S. Jacobs, MD</i>	<i>February 9</i>
<i>John R. Little, MD</i>	<i>February 11</i>
<i>L.A.S. Johnston, MD</i>	<i>February 16</i>
<i>Selwyn A. Willis, MD</i>	<i>March 3</i>
<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
<i>George M. Adams, MD</i>	<i>May 3</i>
<i>John R. Reid, Jr, MD</i>	<i>June 14</i>
<i>Gilbert E. Haslam, Jr, MD</i>	<i>June 15</i>
<i>Thomas A. Trow, MD</i>	<i>June 23</i>
<i>Richard D. Mullett, MD</i>	<i>June 28</i>
<i>Aaron C. Little, MD</i>	<i>July 1</i>
<i>Michael C. Manning, MD</i>	<i>July 3</i>
<i>Hillard E. Denyer, MD</i>	<i>August 8</i>
<i>Edward A. Allgood, MD</i>	<i>August 18</i>
<i>Hugh E. Wilson III, MD</i>	<i>August 27</i>

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47 ACRES, SW 134th and Rockwell, partially wooded, electricity, good water, blacktop 1½ miles to H.E. Bailey (I-44). Good pasture or for development. 789-0395 or 271-2644.

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OB-GYN PARTNER WANTED. Ob-Gyn, Male/Female Board Certified or eligible for immediate partnership with well established lady Ob-Gyn in Shawnee, Oklahoma. Curriculum Vitae to Mrs Lila Nevrekar, MD, 805 East Midland, Shawnee, Oklahoma 74801. (405) 275-4987 evenings and weekends.

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Yet another benefit Valium affords is flexibility.



Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules,

knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

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Injectable Valium® (diazepam/Roche) 

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly; taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over sedation (initially 2 to 2½ mg once or twice daily; increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return: readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity;

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety; 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety; 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary; Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly; repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



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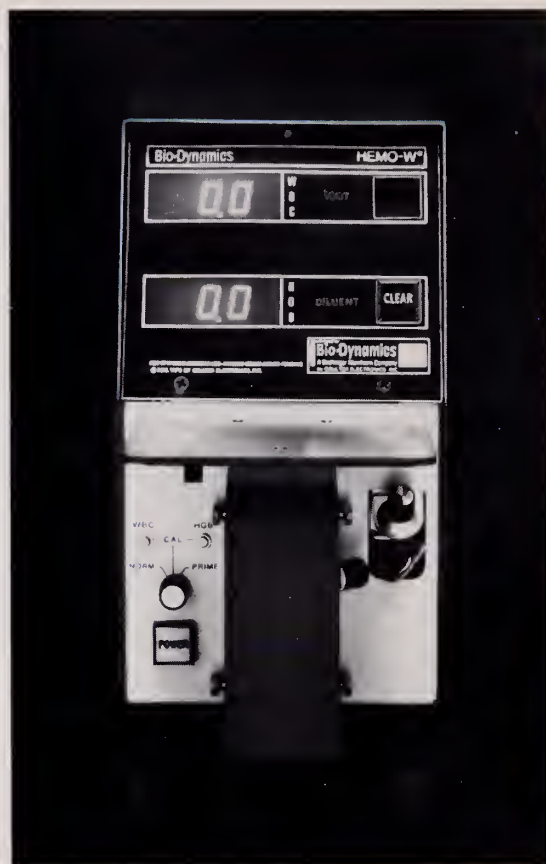
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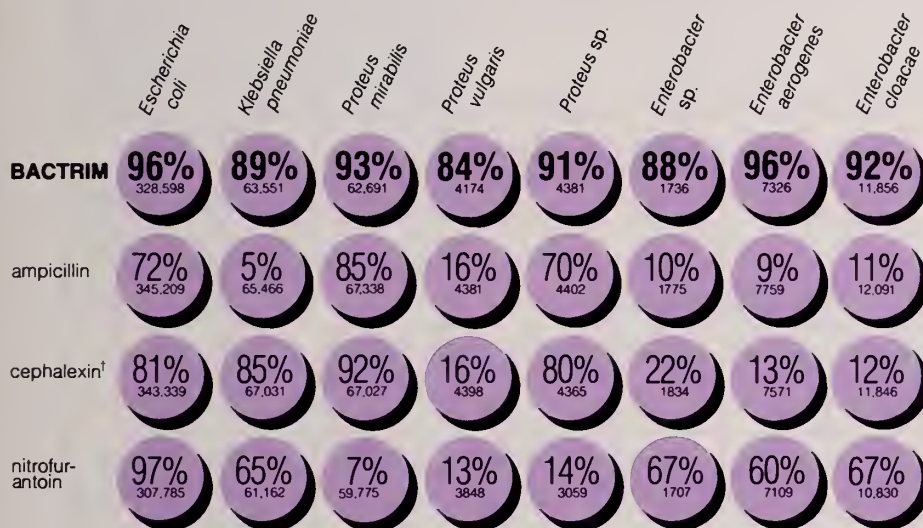
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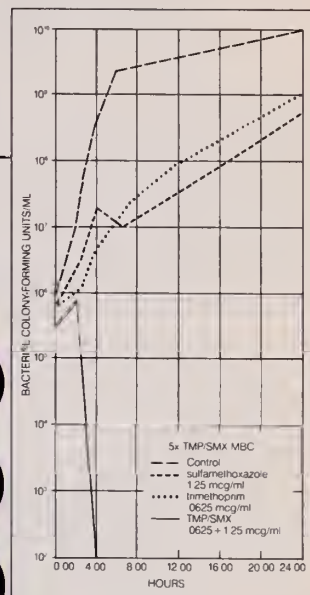
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



¹Analogous to cephalothin, the primary antibiotic disc used in testing.

Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82. Numbers under percentages refer to the projected number of isolates tested.

RAPID IN VITRO DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli* in vitro.¹

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.⁶⁻¹¹

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Maunz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicehandler J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brumfitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Irvani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82.

Bactrim® DS

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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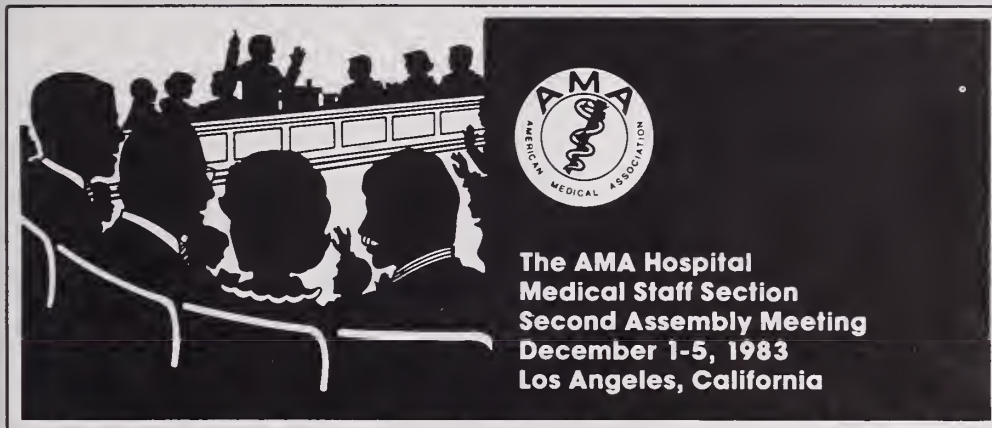
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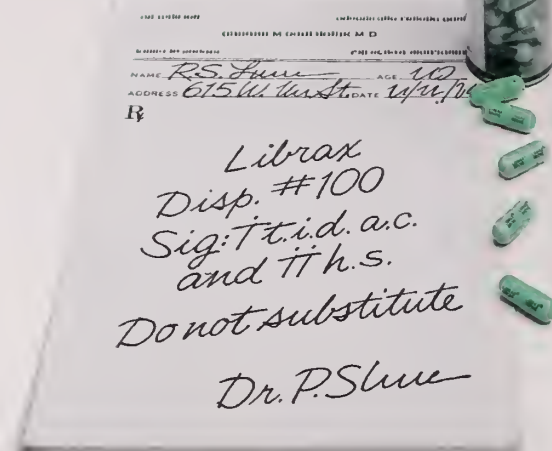
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Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl, Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

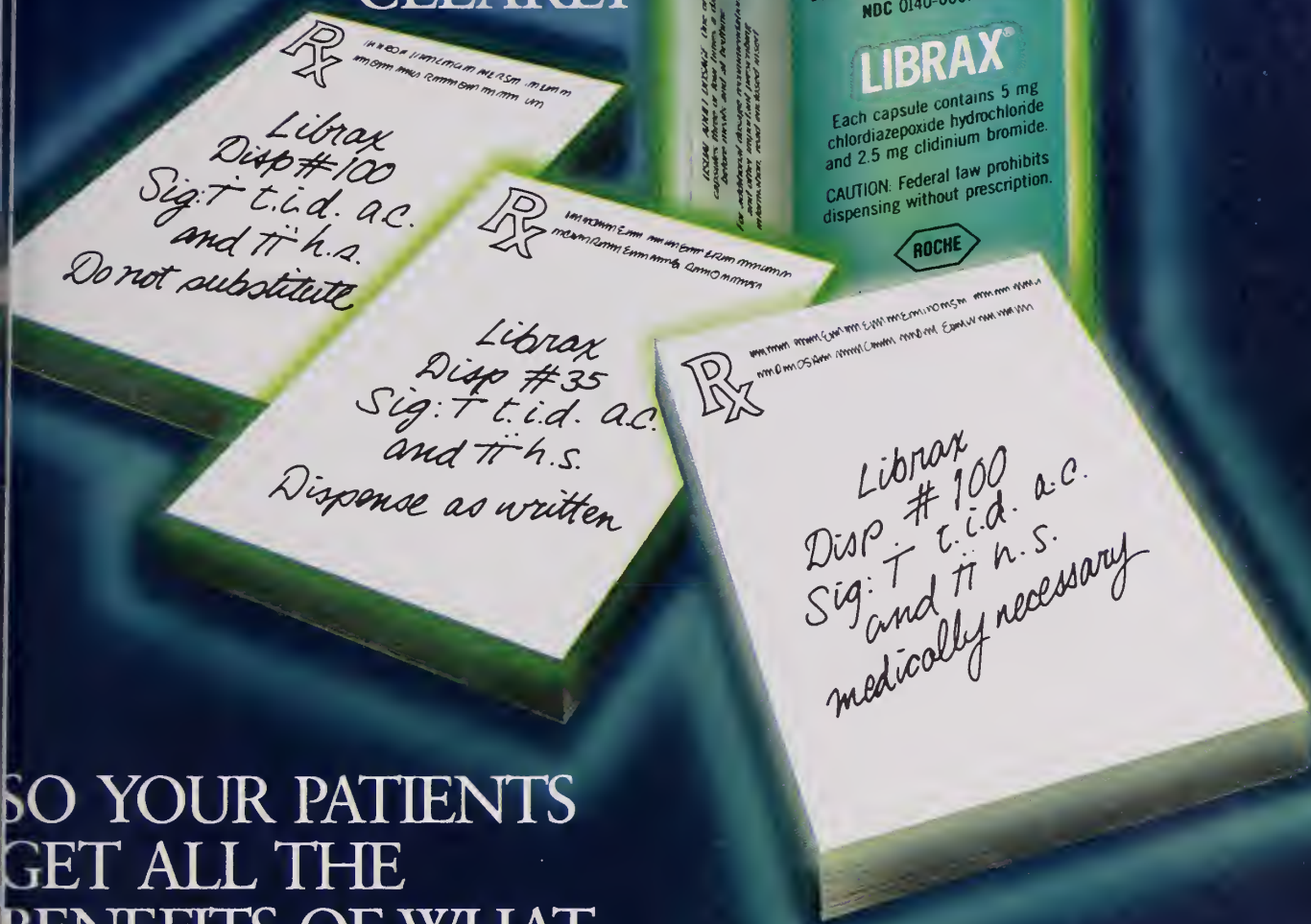
As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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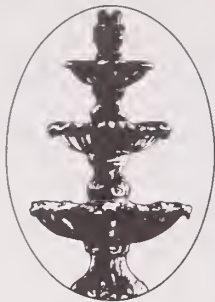
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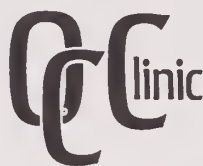
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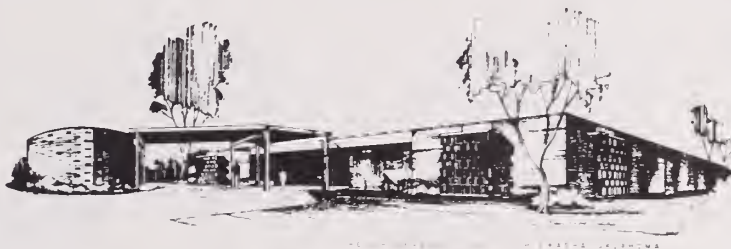
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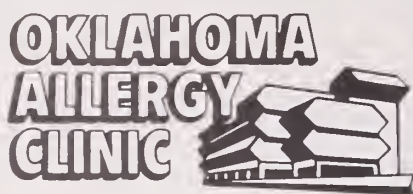
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Skin lesions caused by spider bites can be treated with dapsone, a substance generally used to control leprosy, say Lloyd E. King, Jr, MD, and Riley S. Rees, MD, in a recent issue of the *Journal of the American Medical Association (JAMA)*. The Nashville physicians, associated with the Veterans Administration and Vanderbilt University medical centers, say, "Judicious use of dapsone, starting with a low dose with careful follow-up, should be useful in eliminating necrotic skin ulcers produced by the brown recluse spider bite.

Saint Francis Hospital in Tulsa is announcing the opening of two new services in the new William Building on the medical center campus. The Southwestern Metabolism and Diabetes Center incorporates services for patients with obesity or other metabolic problems as well as diabetes. The Physical Performance Center includes an area for cardiac rehabilitation and an exercise facility. The centers are designed to help people reduce some of the risks associated with heart disease, cancer, and diet-related problems.

Preferred Provider Organizations have attracted 5% of physicians, according to the latest figures from the Socioeconomic Monitoring System of the AMA Center for Health Policy Research. Of those who have joined, 60% said that PPOs increased their certainty of patient loads, 40% said that they reduced out-of-pocket costs for patients, and 27% said they reduced collection problems. Of the 95% who have not joined, 25% said the reason was insufficient reimbursement, while 24% cited extra paperwork.

Chronic emotional difficulties may be the result of damage to the right hemisphere of the brain, whether that damage is suffered early in life or inherited, theorize two Harvard

Medical School researchers. In a recent *Archives of Neurology*, Sandra Weintraub, PhD, and M-Marsel Mesulam, MD, report on 14 patients with a behavioral syndrome, beginning early in life, characterized by interpersonal problems, shyness, visuospatial disturbances, and deficits in communication abilities. "Examination revealed neurologic and neuropsychological signs consistent with right-hemisphere dysfunction," the researchers say.

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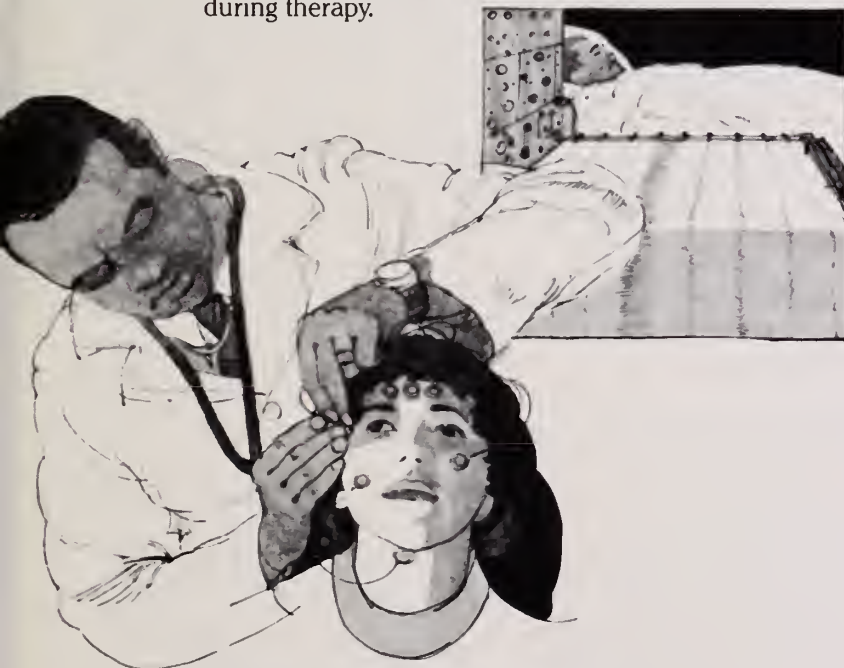
Insulin pump therapy can help insulin-dependent diabetics achieve tight blood glucose control as long as precautions are taken to enhance success, say Philip Felig, MD, Yale University School of Medicine, and Michael Bergman, MD, New York Medical College. Their list of requirements includes: 1) a physician experienced in insulin pump therapy; 2) a motivated patient capable of performing intensive daily self-monitoring of blood glucose; and 3) a health care team to provide day-to-day help in adjusting insulin dose, diet, or exercise. Proof of long-term benefits may take a decade or more as investigators evaluate the role of the insulin pump in preventing or arresting the insidious vascular complications of diabetes.

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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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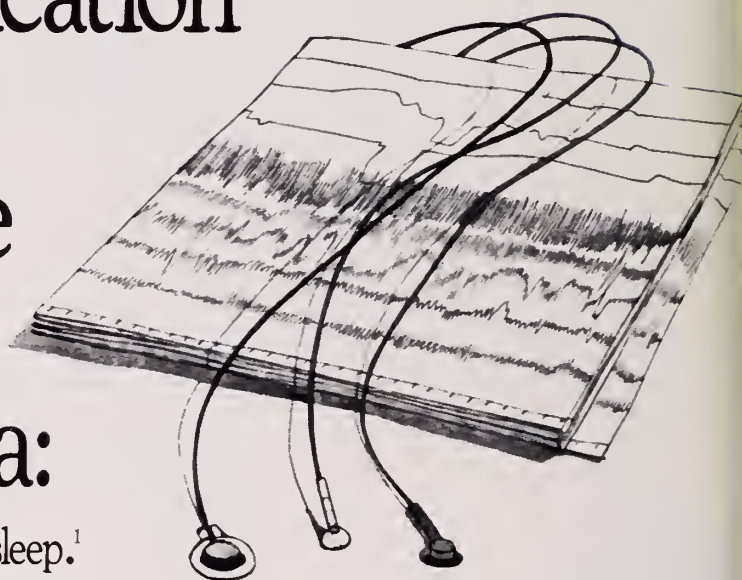
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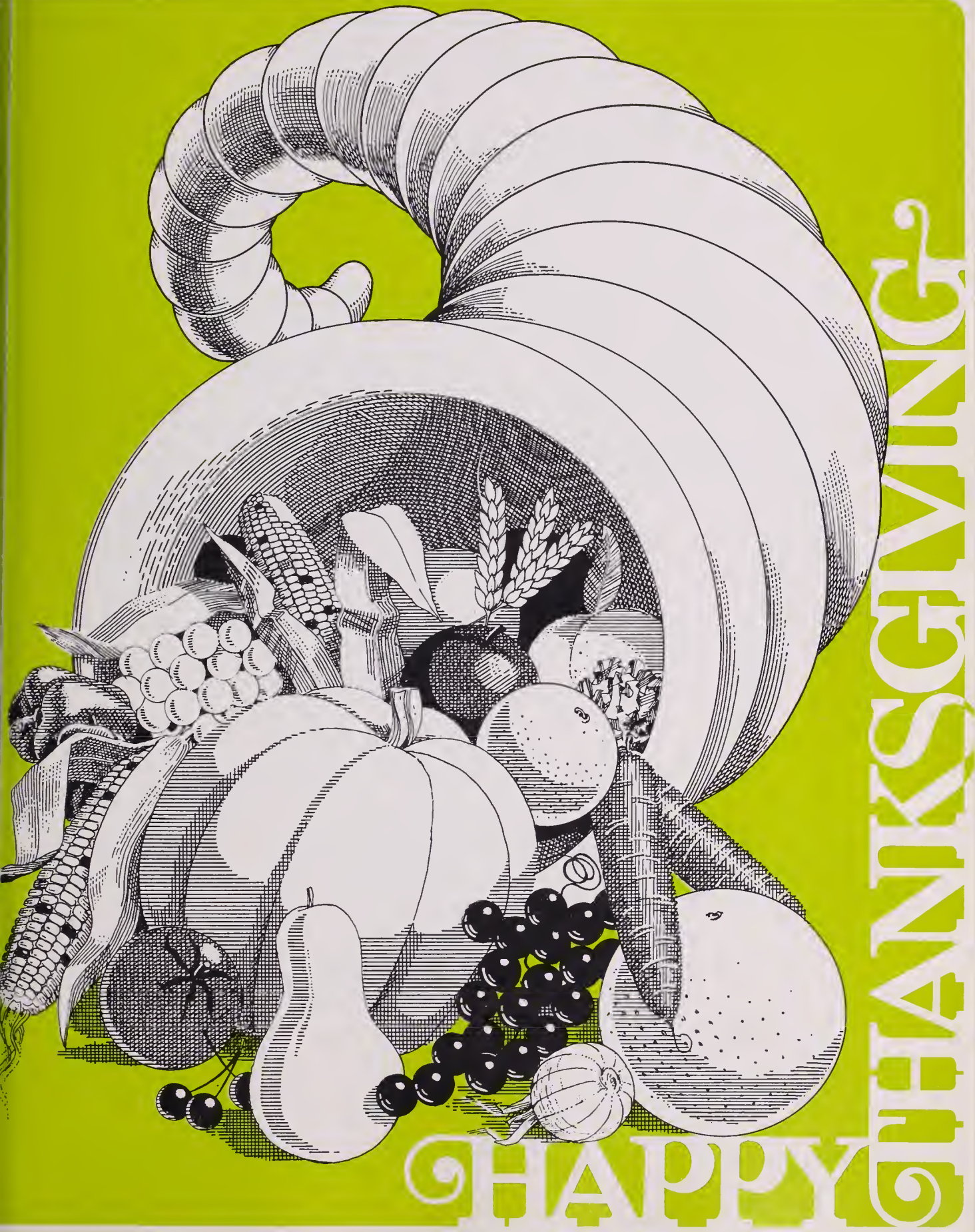
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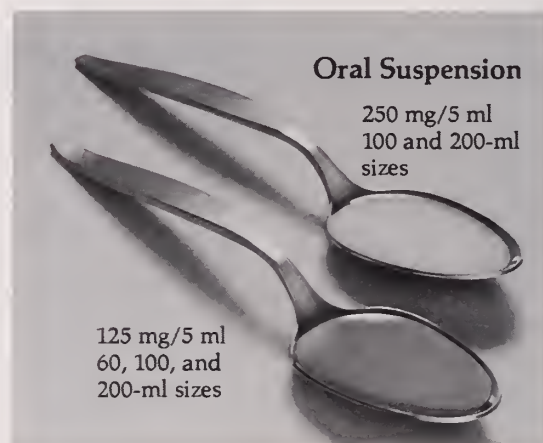
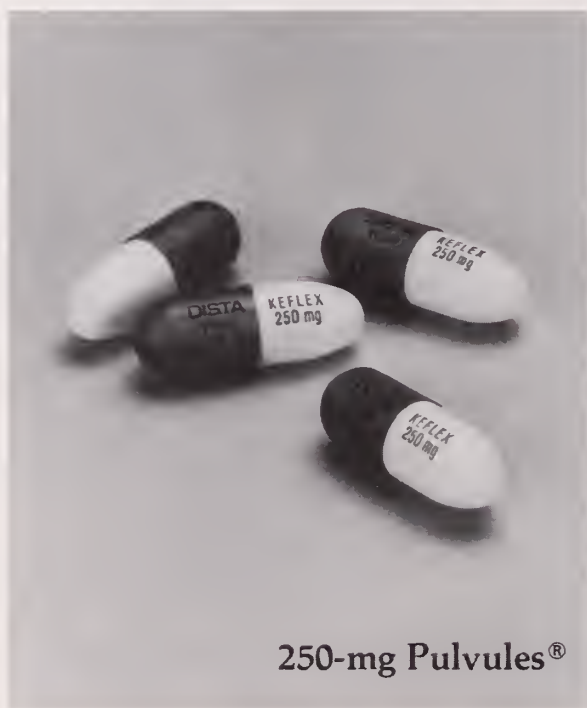
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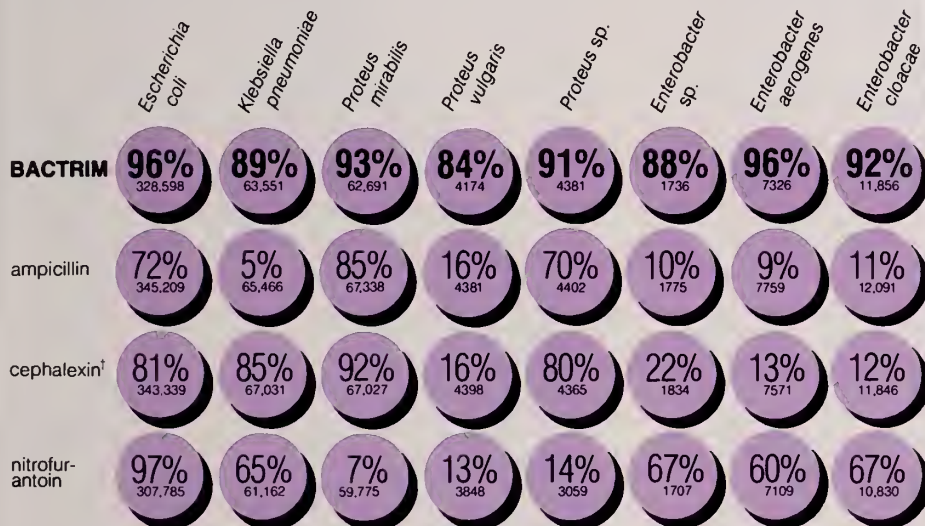
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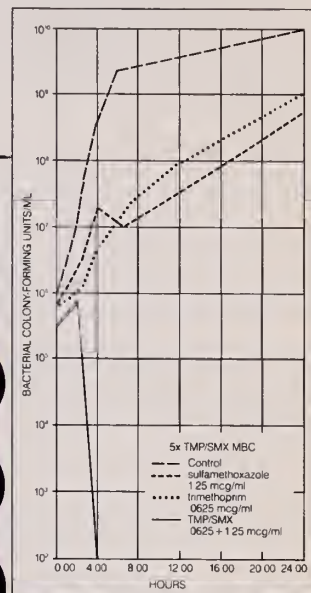
with minimal resistance

Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials



[†]Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID IN VITRO DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli* in vitro.¹

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*^{1,2} and on clinical isolates of *E. coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis* and *Morganella morganii*³—the most common causative organisms of urinary tract infections.⁴ More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.⁵ In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.⁶⁻¹¹

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.^{*} Among urinary tract isolates, resistance has rarely emerged in susceptible strains.^{5,12} Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency. Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)
b.i.d. for recurrent urinary tract infections

^{*}*In vitro* data do not necessarily predict clinical results.

References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Kramer MJ, Maunz YR, Robertson TL, Timmes MD: Morphological studies on the effect of subinhibitory and inhibitory doses of sulfamethoxazole-trimethoprim combination on *Escherichia coli*. Presented at the 12th International Congress of Chemotherapy, Florence, Italy, Jul 19-24, 1981. 3. Spicemander J et al: *Rev Infect Dis* 4:562-565, Mar-Apr 1982. 4. Stamey TA: *Pathogenesis and Treatment of Urinary Tract Infections*. Baltimore, Williams & Wilkins, 1980, p. 13. 5. Ronald AR: *Clin Ther* 3:176-189, Mar 1980. 6. Cooper J, Brummitt W, Hamilton-Miller JMT: *J Antimicrob Chemother* 6:231-239, 1980. 7. Gower PE, Tasker PRW: *Br Med J* 1:684-686, Mar 20, 1976. 8. Cosgrove MD, Morrow JW: *J Urol* 111:670-672, May 1974. 9. Iravani A et al: *Antimicrob Agents Chemother* 19:598-604, Apr 1981. 10. Schaeffer AJ, Flynn S, Jones J: *J Urol* 125:825-827, Jun 1981. 11. Rous SN: *J Urol* 125:228-229, Feb 1981. 12. BAC-DATA Medical Information Systems, Inc., Bacteriologic Reports, Winter Series, 1976-82

Bactrim™ DS (trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrosis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pain, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarthritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some glitoxins, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN,

AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100. Prescription Paks of 20. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100. Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

References:

- Stone PH, Tur ZG, Muller JE: Efficacy of nifedipine therapy for refractory angina pectoris. *Am Heart J* 104 672-681, September 1982
- Aspmann E, Muller J, Goldberg S, et al: Nifedipine therapy for coronary artery spasm. Experience in 127 patients. *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY PROCARDIA® (nifedipine) CAPSULES

For Oral Use

INDICATIONS AND USAGE: 1. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm or when angina is refractory to nitrates and/or adequate doses of beta blockers.

2. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out. In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone.

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug interactions: Beta-adrenergic blocking agents. (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates. PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianalgesic effectiveness of this combination.

Digitalis. Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers. The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed. Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating adjusting and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 3D times the maximum recommended human dose.

Pregnancy. Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients; transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally the following have been reported: muscle cramps, nervousness, dyspnea nasal and chest congestion, diarrhea constipation, inflammation joint stiffness, shakiness, sleep disturbances blurred vision difficulties in balance dermatitis pruritus, urticaria, fever sweating, chills, and sexual difficulties. Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in less than 0.5% of patients.

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LOH, SGOT and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC D069-2600-66) 30D (NDC D069-2600-72) and unit dose (10x1D) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59 to 77 F (15 to 25 C) in the manufacturer's original container.

More detailed professional information available on request

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Quotes from an unsolicited letter received by Pfizer from an angina patient. While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procordia nor will they all respond to the same degree.

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"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,¹ taking fewer nitroglycerin tablets,² doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).



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for the varied faces of angina

*Procordia is indicated for the management of:

- 1) Confirmed vasospastic angina.
- 2) Angina where the clinical presentation suggests a possible vasospastic component.
- 3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

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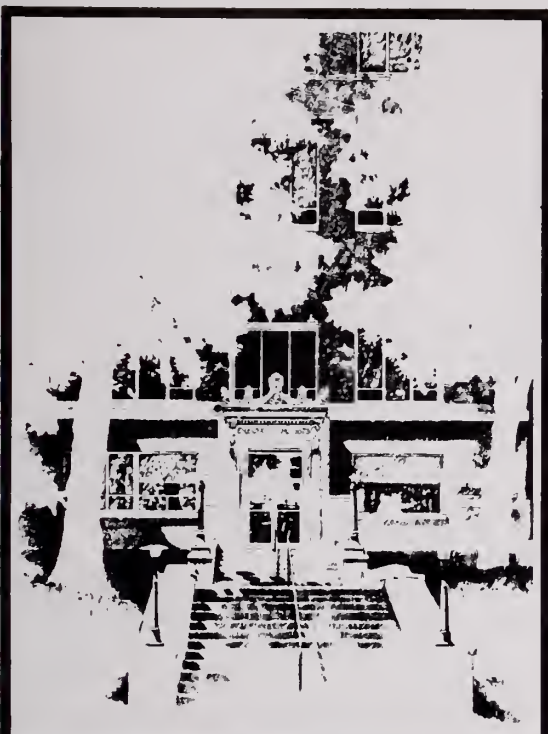
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INDICATIONS: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component.
WARNINGS: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Adverse reactions have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage, one tablet daily. Not recommended for children. Available on prescription only.
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1. Dixon RE: *Ann Intern Med* 89(Part 2):749-753, Nov 1978. 2. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME: Philadelphia, Lea & Febiger, 1980, p. 1114

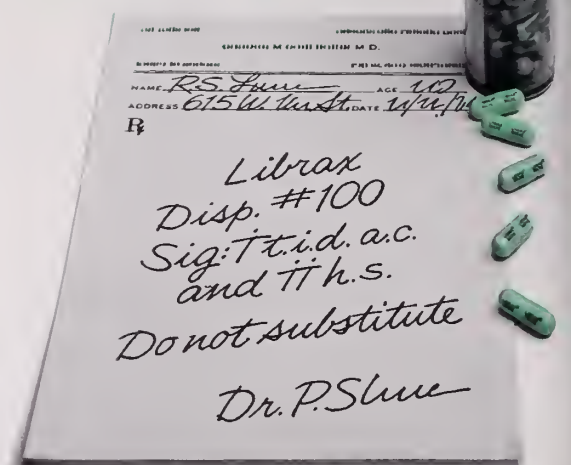
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

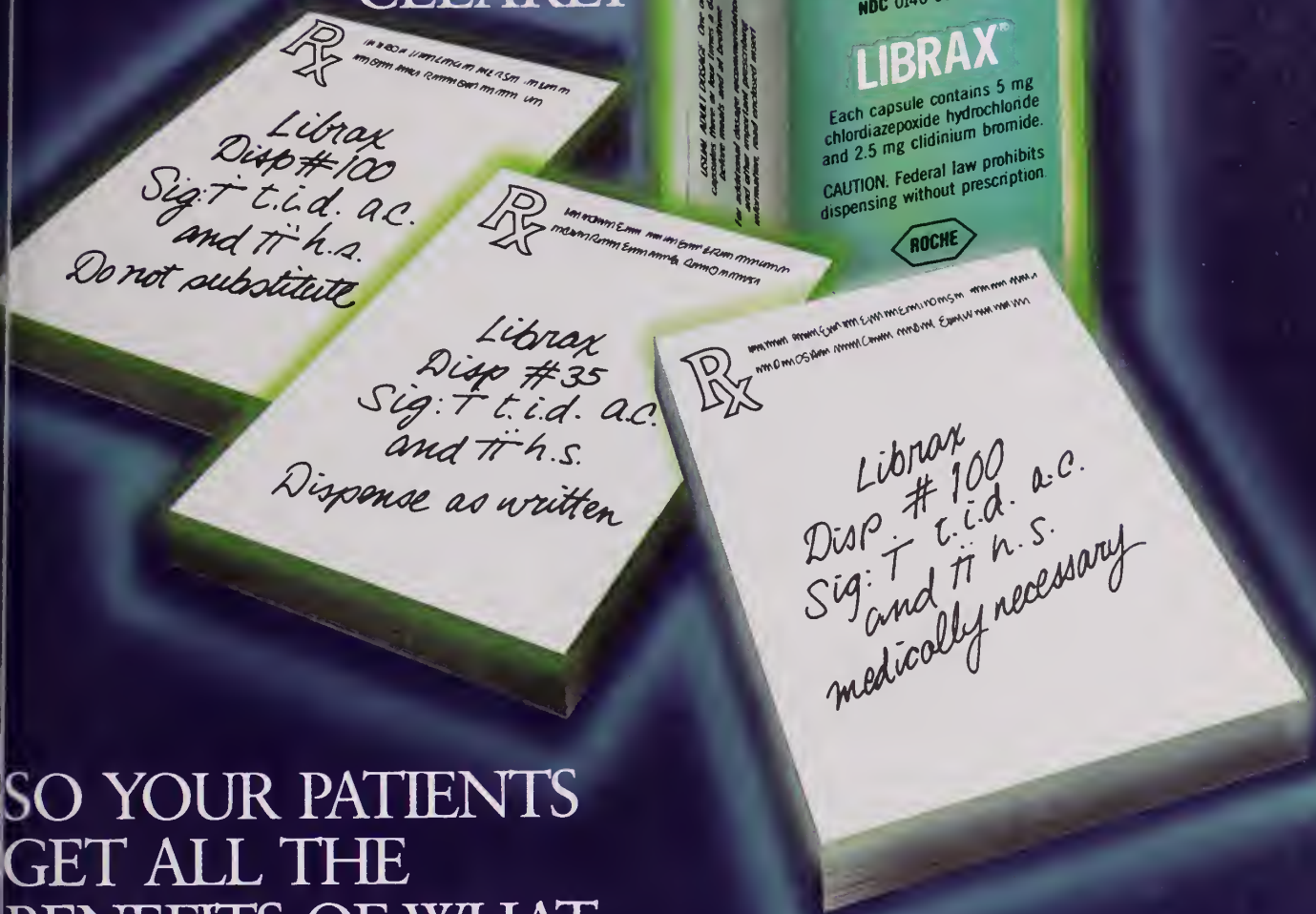
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Isn't It Nice to Feel Wanted?

Insuring physicians' health has been viewed as economic poison to the commercial health insurance industry.

These companies have said in a chorus that a doctor group is the sorriest lot in a sorry business. Physicians, they say, may neglect their own aches and pains, but they're knee-jerk quick to pamper their partners . . . and they're likely to entice their employees into the hospital for a rest . . . and they're sure to slap mom or junior in the ICU at the slightest sign of malaise.

These health care financiers would sooner insure a sky diving club, or a bomb disposal squad, or the Indianapolis Speedway. They declare that taking such a dive, or bellying up to such a bomb, or sliding into such a fast lane requires bonus premium bucks. Or scanty coverage. Or both.

Then along came PLICO — the association-owned carrier whose founding purpose was to stop exploitation in the professional liability arena. After our malpractice protection program settled down comfortably as the nation's best buy, the physicians who run PLICO reasoned that health insurance equity should be their next goal.

It seemed to them that the money changers had dealt the profession a bad hand. So, a la the professional liability story, the PLICO HEALTH product now available to us has matured into another best-buy situation — about 40% less costly than comparable coverage from other carriers.

Today, about 2,300 physicians and 4,200 of their employees and another 11,000 of their dependents are healthier, wealthier, and wiser because of PLICO HEALTH. The benefits of PLICO's top-of-the-line \$134-a-month policy

exceed those of policies costing \$180 to \$200 from other carriers. PLICO's coverage is broad, payments per illness or per lifetime are unlimited, and the claims service is swift and considerate.

Aside from simply appreciating PLICO HEALTH's value to the medical profession, there may be a collateral observation to be explored on another day in another editorial. Like extending PLICO's apparent discovery of a 40% overcharge to the nation's total health care tab, nearly all of which is financed through private or government insuring mechanisms. This astronomical sum could be reasonably associated with nonproductive administrative waste, which about everybody would classify as "bad." Making a distinction between good and bad expenses might well be considered as the federal government launches its campaign to curb rising health care costs.

So, PLICO HEALTH is at least a fine service to OSMA members — and at best it could demonstrate a great potential for nationwide savings if all of the money brokers possessed the same capacity for taut management and if their motives were as pure as PLICO's.

PLICO HEALTH, the seventeen physicians, and the OSMA Executive Director who sit on our company's Board of Directors are deserving of our support. Let's help them prove their point and, at the same time, help ourselves to the significant savings and service advantages which are ours for the asking.

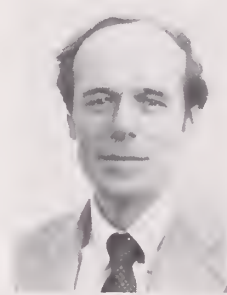
There's no better time than now. An "open enrollment" period is underway and no proof of insurability is required if you act soon. Details are available by calling the PLICO Sales and Service Department at (405) 843-0215.

Isn't it nice to feel wanted?

— Don Blair
Executive Vice-President, PLICO

Work—To Be Continued

The work of the Oklahoma State Medical Association is often an example of the labor of several persons building on the previous work of others. This is readily apparent in our current efforts with our Medicare Demonstration Project, also known as the Health Bonus Option Program. This proposal has been developed by Dr Perry Lambird. It has been considered and endorsed by our House of Delegates and Board.



The proposal is much too complex and detailed to be entirely summarized here. However, central features include voluntary enrollment of Medicare beneficiaries at age 65 in Oklahoma with emphasis on a wellness bonus of \$200 a year to beneficiaries not presenting claims in that year. The insurance carrier to administer the program would be selected jointly by the OSMA, the Oklahoma Osteopathic Association (OOA), the Oklahoma Hospital Association (OHA), and the Health Care Financing Association (HCFA). Deductibles and coverage would remain the same as for nonparticipants, and individual participants would also have established a separate trust account on which half of the interest would be tax free. After the death of the Medicare recipient, funds remaining in these accounts would be used in the general Medicare trust fund. The carrier would reinsure for catastrophic

coverage so that there is an upper limit of \$600 for which the carrier will be responsible. Funding to the carrier from HCFA will be based on an average per capita, part A and part B, Oklahoma expenditures.

As has been widely reported in the lay press and thoughtfully discussed in a recent *Wall Street Journal* (August 29 issue), the basic concept of making the *consumer* of health care more responsible for wise expenditure is fundamental to the control of health care costs. Early indication from our own wellness bonus with PLICO Health suggests that in our Medicare-age group policyholders, the wellness bonus did indeed decrease utilization. Our results in Oklahoma are certainly not long-term, but they do have some promise.

We have carefully discussed our proposed Medicare Demonstration Project with officials of the American Medical Association. In response to the action of our Board of Directors in August, we are now proceeding to the next step in Washington. Obviously, this step is not a simple one, and it involves the support of the Oklahoma Congressional Delegation, administration, and officials at HCFA. This is indeed an ambitious undertaking. If the project does become operational in the future, all physicians in Oklahoma and their Medicare patients will be directly and personally involved. Only future authors and readers of this page will be able to measure its success.

George H. Kamp, M.D.

Adjuvant Therapy in Rectal Carcinoma

T.J. BRICKNER, JR, MD
GEORGE W. SCHNETZER III, MD
W. STONE, MD

Surgery alone is not adequate treatment for the vast majority of rectal carcinomas.

Adjuvant treatment can have a significant impact on survival in this common disease.

Adenocarcinoma of the rectum remains a prevalent and serious disease in this country, being one of the two leading causes of cancer deaths in adults of both sexes. More than 38,000 cases will be seen in 1983 according to the American Cancer Society. Their studies have indicated no significant change in the death rate from this disease in the past two decades.¹

Surgical techniques and capabilities have been refined over the years, allowing more patients to undergo radical surgical procedures with curative intent. These innovations have allowed an increasing number of patients to be treated by an anterior resection with primary anastomosis, thus avoiding a permanent colostomy. In spite of these advances, postsurgical

failures with recurrences and eventual death remain a serious problem as is seen by the number of failures reported during the first fifteen years after the surgery.^{11,12,36,42}

A review of the current literature reveals several significant points:

1. Surgery alone is not adequate treatment for patients in whom the tumor involves more than the mucosal surface of the rectum.
2. Five-year survival figures are insufficient for the evaluation of treatment program effectiveness in this disease.
3. Local and regional recurrences play a significant role in terms of both morbidity and mortality.
4. Radiation therapy has been demonstrated to be an effective adjuvant to surgical treatment.

Staging

Various staging systems in carcinoma of the rectum have been developed and utilized in the past. The original Dukes system forms the basis in most of these and includes these subgroups:

CARCINOMA / *Brickner, et al*

Stage A — Disease limited to the bowel wall without extension through the wall or involvement of lymph nodes;

Stage B — Disease penetrating the bowel wall and involving tissues adjacent to the rectum, with lymph nodes negative for metastasis;

Stage C — Any disease with positive lymph nodes in the surgical specimen;

Stage D — Patients with distant metastatic disease.

Astler-Collins has developed a modification of the Dukes system and Gundersen et al have added further changes to this. These various staging systems are represented in Table 1.¹¹ For most of this analysis, however, the original Dukes A, B, C, and D system will be utilized since the majority of the literature reports in this fashion.

Inadequacy of Surgery Alone and Five-Year Survival Data in Advanced Disease

The insufficiency of surgical treatment alone in advanced disease and the inadequacy of five-year survival figures are supported by review of the current literature. The results of Eisenberg, published in 1982, show excellent five-year survival figures but demonstrate a significant continuing death rate between the

System		
Dukes'	Modified Astler-Collins	Description
A	A	Nodes (—); lesion limited to mucosa
	B ₁	Nodes (—); extension of lesion through mucosa but still within bowel wall
B	B ₂ *	Nodes (—); extension through entire bowel wall
C	C ₁	Nodes (+); lesion limited to bowel wall
	C ₂ *	Nodes (+); extension of lesion through entire bowel wall
D	D	Distant metastases

*Separate notation is made regarding degree of extension through the bowel wall: Microscopic only (m); Gross extension confirmed by microscopy (m&g); Adherence to or invasion of surrounding organs or structures (B.&C.) (From Gunderson & Sosin)

Stage	Number	5 Year %	10 Year %
Dukes' A	75	87.9	83.3
Dukes' B	107	79.4	64.0
Dukes' C	158	29.1	18.2
Dukes' D	117	3.6	3.6

(Eisenberg)

Stage	Number	5 Year %	10 Year %	15 Year %
Dukes' A	232	88	80	77
Dukes' B	260	76	62	59
Dukes' C	214	43	39	39
Dukes' D	150	4	3	3

(Pihl et al)

fifth and tenth years in Stage B and C disease (Table 2). Eisenberg makes the interesting observation that of those patients who died from their tumor and who were examined at autopsy, 80% had a recurrence within the pelvis.³⁹

Table 3, the results of a personal series of over 1,000 cases reported by Pihl et al once again demonstrates that the five-year survival rate is not a true indication of the disease status. This is true even in Stage A disease but most especially in Stage B and C disease.⁴²

Comparing the two studies, it is apparent that Stage A disease, treated with surgical procedures only, does relatively well with approximately 80% survival at ten years. Stage B disease, however, shows a significant and progressive death rate past ten years with survival of approximately 60% at ten years. The latest death reported from colon cancer recurrence was at 14½ years.

The American College of Surgeons has recently completed a survey of over 20,000 cases of rectal carcinoma through 1979.³⁶ Cases were collected in 46 states from 441 hospitals which met criteria for approval by the American College of Surgeons as cancer treatment facilities. The five-year survival rates in rectal carcinoma are given in Table 4 for the various stages of disease, including Stages B, C, and

**Table 4. — Rectal CA Survival
(20,000 Cases)**

Stage	5 Yr Survival	5 Yr NED
Dukes' A	56%	46%
Dukes' B	33%	24%
Dukes' C	32%	23%
Dukes' B+C	20%	14%
Dukes' D	3%	3%

(American College of Surgeons, 1980)

B+C patients; that is, patients with extension to perirectal tissues and positive lymph nodes. In addition, the disease-free figures given suggest that 10% or more of the patients in Stages B and C surviving at five years were surviving with persistent disease.

Importance of Loco-Regional Recurrence

Gundersen et al, in their study of the second-look laparotomies performed on Stage B and C patients at the University of Minnesota, confirmed the earlier work of Moertel which demonstrated that approximately one-half of the patients dying of recurrent cancer of the rectum died from the effects of the local disease recurring in the pelvis, especially from ureteral obstruction or bowel obstruction.⁴⁰ In Gundersen's analysis of 81 patients with a known cause of death, 60% died from the effects of local recurrences. Local recurrence was present in over 90% of the patients in that series who demonstrated failure. Approximately half of the patients who failed had local and regional recurrence only, without distant metastasis. Less than 10% of the patients had distant metastasis present without local or pelvic failure. Of particular importance was

the fact that approximately one-half of the patients had their local recurrences within areas easily encompassed by customary radiation therapy fields.^{11,12}

These studies, therefore, suggest that surgery alone is not adequate treatment for Stage B and C disease, that five-year survival figures alone are not adequate to demonstrate control of disease and that local and regional failure represents a significant factor, not only as a cause of death, but as a cause of the morbidity and decreased quality of life from which the patients suffer.

Chemotherapy As a Surgical Adjuvant

Some type of effective surgical adjuvant treatment surely is needed in Stage B and C disease. Controlled adjuvant chemotherapeutic trials in colorectal carcinoma have been completed by the Veterans Administration Surgery Oncology Group (VASOG),^{44,45} the Cooperative Oncology Group Study (COG),⁴⁶ and the Gastrointestinal Tumor Study Group (GITSG).^{47,48} In all cases, 5-fluorouracil (5FU) or 5-fluoro-2-deoxyuride (FUDR) were utilized in varying dosage schedules. In both VASOG studies, a slight, statistically insignificant survival advantage accrued to the treated groups. The COG study, while producing substantially similar results, disclosed a statistically significant prolongation of disease-free survival in Dukes' C colorectal lesions, and a significant prolongation of overall survival in a small (29 patients) subgroup of patients with rectal cancer. The GITSG study, limited to rectal cancer, is in progress, but already has produced some early evidence of chemotherapeutic effectiveness.

Radiation Therapy As a Surgical Adjuvant

It has been demonstrated in the past that radi-

**Table 5. — Comparative Survival of Preoperative Irradiation
in Rectal Cancer**

Author	No. Pts	Dose Preop	Patient Characteristics	5-yr survival Preop Rad (%)	Control (%)
Rider	70	500	Stage C	37	19
Dwight	305	2,500	Low Rectal	41	28
Kligerman	31	4,500	All Stages	41	25
Stevens	57	5,000+	All Stages	53	38

ation therapy is an effective treatment method for recurrent carcinoma of the colon and rectum. More than 80% of the patients treated for recurrent disease have shown excellent palliative responses with reduction in tumor masses, relief of pain, and control of bleeding.^{2,3,9,35,38} It was reasonable then that radiation therapy should be studied as an adjuvant to surgery in this disease, especially since it had demonstrated definite advantages as an adjuvant in other disease sites, including bladder, endometrium, and many head and neck cancers.

Preoperative radiation therapy has been evaluated by numerous authors, and a brief summary of the studies is presented in Table 5.^{8,14,26,27,32,33,37} The exposure to radiation has varied from 500 rads in a single exposure to over 5,000 rad in a period of 5 to 8 weeks. In each of these series, either all or some subgroup of patients with rectal carcinoma have improved five-year survival with the use of preoperative radiation.

In Rider's study utilizing a single preoperative exposure of 500 rads, all patients were treated within eight hours of surgery, but treatment proved to be beneficial only in Stage C patients.²⁶ The reasons for this finding remain obscure.

Roswitz, Dwight, and Higgins reported a Veteran's Administration study of 700 patients receiving 2,000 rad delivered preoperatively to rectal lesions.²⁷ These patients showed a statistically significant benefit for Stage C patients, particularly for those patients undergoing abdominal perineal resection. This was in part due to the study design. Patients whose tumor was higher than 8 cms from the anal verge received only 2,000 rad in two weeks followed

by immediate surgery, in the vast majority of the cases, anterior resections. In patients who had tumors within 8 cms of the anus, the same 2,000 rad was delivered to whole pelvis fields, plus an additional 500 rad during the same two weeks as a boost to the perineum. This resulted in a higher dose of 2,500 rad in the two weeks to those patients with lower tumors who underwent abdominal perineal resections. Thus, the improved results for the abdominal perineal resection group may be related more to increased radiation dose than to the tumor location.

Although the numbers of patients in these studies are not great, and the techniques of preoperative treatment showed considerable variability, not only in dose but in field size, it is still impressively demonstrated that preoperative irradiation not only improves five-

The five-year survival rate is not a true indication of the disease status.

year survival, but markedly decreases the number of positive nodes found at surgery when compared to either a control group of patients operated concurrently or to historical controls from the same institutions.

Thus, it would appear that tolerable doses of external beam radiation therapy are capable of sterilizing microscopic extensions or microscopic metastatic disease in carcinoma of the rectum.

There are valid objections to the routine application of preoperative radiation therapy, especially in the higher dose ranges. A significant delay from the time of diagnosis until surgical resection results in most instances. If doses above 2,000 rads are used, the delay is usually several weeks. In addition, a significant number of patients with pathologic Stage A or B₁ disease would receive preoperative radiation therapy; these patients probably do not benefit and would do well with surgery alone.

The work of Stevens et al^{33,34} suggests that high dose preoperative radiation therapy, even with small fields, produces significant risk of increased complications in anterior resections and requires special surgical procedures and protective colostomies. For these and other reasons, Gundersen and other authors have

**Table 6. — National GI Study Group
December 31, 1980**

Study Terminated: Median Follow-up = 2½ years
50 Cases Each Arm With Good Balance*

Treatment Arm	Recurrence Rate
Surgery Only	49%
+ RT & Chemo	28%
+ RT	36%
+ Chemo	39%

$p = < 0.05$

*23 Dukes C

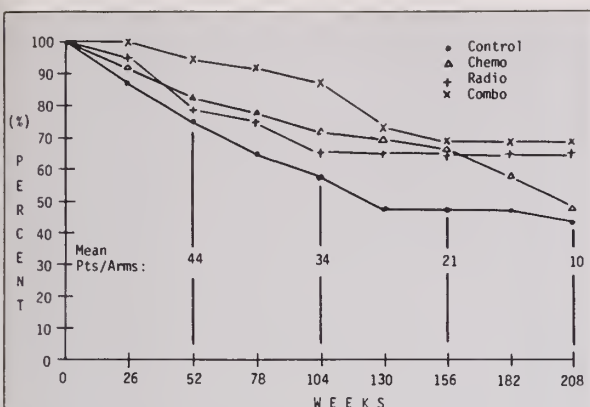


Figure 1. — Probability of Disease-Free Survival by Treatment

elected to reserve postoperative radiation therapy for those patients who were at the greatest risk of locoregional failure. Therefore, patients with Stage B₂ and C disease would be treated and those with Stage A and B₁ disease would not be treated since surgery was considered adequate treatment. Patients with Stage D disease at surgery would be treated for palliation only.

Studies performed at the Latter Day Saints Hospital,¹¹ M.D. Anderson Hospital,^{19,20} and at Massachusetts General Hospital,⁶ as well as other institutions,³⁸ have indicated that in Stages B₂ and C disease, postoperative radiation therapy to the pelvis is of significant benefit. Doses of 4,500 rad to 6,000 rad with special techniques have markedly reduced the probability of local failure. Patients with similar disease stages from these and other institutions have demonstrated a local failure rate of 40% to 45% without postoperative radiation

therapy. However, in those patients receiving full dose postoperative radiation therapy to the pelvis and primary tumor, the failure rate has been 6% or less.^{20,38}

Some problems have been encountered, especially in patients who have undergone abdominal perineal resections, with small bowel that has been trapped within the pelvis and falls within the treatment field. High dose radiation is capable of causing radiation enteritis which can be a serious and potentially fatal complication. Meticulous treatment techniques have been developed to reduce the possibility of small bowel injury, but this remains the limiting factor of high-dose postoperative radiation therapy.

Perhaps the best demonstration of the role of postoperative radiation therapy in Dukes' B₂ and C disease has been made by the National Gastrointestinal Tumor Study Group.^{16,49} Since 1975, 227 patients were entered into a protocol randomizing to surgery alone, surgery plus radiation therapy (4,000 to 4,800 rad), surgery plus chemotherapy (5FU and methyl CCNU), and surgery plus radiation and chemotherapy. In 1980 it became apparent that at least one treatment arm was doing less well than the other arms. In keeping with the ethical considerations mandated at the beginning of the trial, the code was broken. As can be seen in Table 6, at a median followup of 2½ years, the surgery-only arm had a recurrence rate of 49%, while the surgery plus chemotherapy arm was 39%, and the radiation and radiation plus chemotherapy arms were 36% and 28% respectively. The study was then modified and the surgery-only arm was dropped. Figure 1 shows the probability of disease-free

HISTOLOGICAL DIAGNOSIS OF RECTAL CANCER

↓
500 RAD PREOPERATIVE (IRRADIATION)

↓
SURGERY

↓
PATHOLOGICAL STAGING

↙
STAGES A B₁

↓
NO FURTHER TREATMENT

↘
STAGES B₂, C₁, C₂

↓
4500 RAD/5 WKS POSTOPERATIVE IRRADIATION

Figure 2.

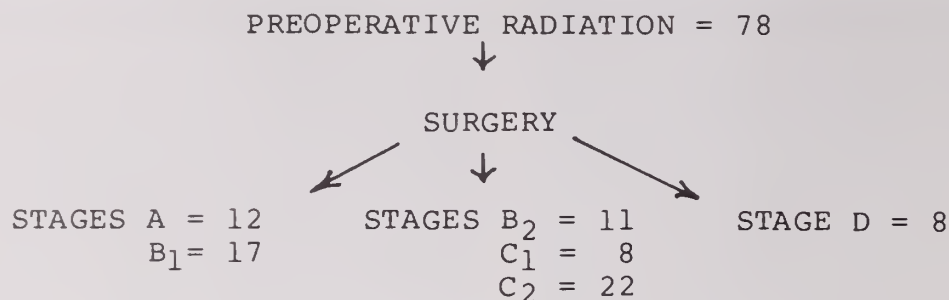


Figure 3. — Distribution of Patients by Pathologic Stage

survival by treatment arm at four years. The numbers of patients in each arm at three and four years decrease, making statistical significance difficult to establish. It is interesting to note, however, that both arms including radiation therapy appear to have plateaued at approximately 2 to 2½ years and that the disease-free survival rate remains stable at 65% to 70% for these arms. The two arms not including irradiation appear to have a progressive decrease in survival rate throughout the entire four-year period.

In an effort to gain the advantages and avoid the disadvantages of these two basic treatment schemes, the group at Thomas Jefferson University has utilized a combination of single exposure preoperative radiation therapy similar to Rider's study with a selected postoperative treatment schedule.¹⁷ This "selective sandwich technique" is outlined in Figure 2. The results in the first 78 patients entered into the study are given in Figure 3. All patients received 500 rad preoperative radiation therapy followed by surgery. Twenty-nine patients were found to have Stages A and B₁ and required no further treatment. Eight patients were found to have extensive local disease or liver metastasis and were treated with palliative intent. The remaining 41 patients with Stages B₂, C₁, or C₂ disease were scheduled to receive postoperative radiation therapy. Sixteen of these patients did not receive postoperative radiation because of physician or patient refusal or in two instances, postoperative complications.

Table 7 represents the results of those 29 patients with Stage A and B₁ disease. Note that there were no local or regional recurrences. Two patients developed distant metastasis and died of their cancers. It does not appear, therefore, that in any of these 29 patients, post-

operative pelvic radiation therapy would have been of benefit.

Table 8 presents the results of the 41 patients with Stage B₂, C₁, or C₂ disease. Those 16 patients who received the preoperative but not the postoperative irradiation had a 38% failure rate with 25% of them showing local recurrence within the pelvis. The remaining 25 patients who received their planned postoperative therapy showed no local recurrences and only two developed distant metastasis for a total failure rate of only 8%.

Table 9 presents an analysis of the results of the Jefferson experience compared with yearly survival rates over the first four years of the other previously discussed preoperative series. Note the stabilization of the survival curve after two years, suggesting that losses in the

Table 7. — Status of Patients, Stage A & B₁ (500 Rad Preop Radiotherapy Only)

	No. of Pts	Recurrence		Dead	
		Local/Distant		Cancer/Other Causes	
Stage A	12	0	1	1	1
Stage B	17	0	1	1	0

Table 8. — Patterns of Recurrence in Stages B₂, C₁, & C₂

Irradiation	No of Pts	Local Recurrence	Distant Metastasis	Total
Preoperative only	16	4	2	6 (38%)
Preoperative + postoperative	25	0	2	2 (8%)

first two years were those with pre-existent clinically undetectable metastatic disease. Although the numbers in this study are small, it suggests a significant role for the selective sandwich technique. To date there has been only one episode of serious small bowel injury which required surgical intervention; this patient has recovered, is doing well, and is free of disease.

Byfield,⁵ Sischy,³⁰ Smith,³¹ and others^{4,7} have reported clinical and experimental models demonstrating that 5FU may act as a radiation sensitizer for tumors of the GI tract. In the National GI Tumor Study Group, 5FU and methyl CCNU were given during and after radiation therapy in an effort to improve results. This, however, resulted in a significant increase in complications, both hematopoietic and gastrointestinal.⁴⁹ Mittelman feels that methyl CCNU poses the primary problem in this regard and has suggested that this agent be dropped in future studies.⁵⁰

Byfield and Sischy have reported on the repetitive use of 5FU by three- or four-day constant infusion technique during radiation therapy.^{5,28,30}

Table 10 shows the results in some 42 patients (from the work of Smith and Sischy^{30,31}) with adenocarcinoma of the rectum greater than 4 cms in diameter who received moderate dose preoperative radiation therapy in combination with 5FU infusions. Seventy-nine percent of these patients had negative nodes at surgery, though one would expect only 35% to be node-negative. More than half of the patients showed a reduction of greater than 50% in tumor size and a quarter of the patients had only microscopic residual disease present at the time of surgery some five to six weeks later. Twenty percent of the patients had no

Table 10. — Adenocarcinoma of the Rectum Greater Than 4 cm			
42 Patients	— Neg nodes	33	79%
	> 50% Reduction	26	62%
	Micro residual	10	24%
	No residual	9	21%
(Smith and Sischy)			

residual disease which could be identified in the surgical specimen. This basic protocol is similar to that used by Sischy and others for the treatment of squamous cell carcinoma of the anus. It would, therefore, appear that a combination of radiation therapy of 4,000 to 5,000 rad in five to six weeks directed to the rectum and pelvis combined with two four-day cycles of 5FU infusion is quite effective as a preoperative treatment for selected adenocarcinomas of the rectum as well as for

5FU may act as a radiation sensitizer for tumors of the GI tract.

epidermoid tumors of the anus. Our personal experience with this treatment technique in patients has revealed marked tumor regression in most patients and complete clinical disappearance in three cases.

The Clinical Cancer Research Committee of the Natalie Warren Bryant Cancer Center, comprising the medical oncology, radiation oncology, and colorectal surgical services, has formally reviewed this information and has developed a rationale for the treatment of rectal carcinoma based upon the use of five disease categories defined primarily by preoperative clinical evaluation:

Category I. Patients with limited disease not requiring a radical resection for curative intent;

Category II. Patients with disease in the upper rectum in whom the surgeon feels that an anterior abdominal resection is the appropriate surgical procedure;

Category III. Patients with disease in the lower rectum in whom the surgeon feels that the required procedure is an abdominal perineal combined resection;

Table 9. — Survival Results of Adjuvant Radiotherapy for Rectal Cancer					
Study	Radiotherapy Dose	Percent Survival			
		1 yr	2 yr	3 yr	4 yr
Dwight	2,000 Rad	78	70	52	44
Kligerman	4,000 Rad	75	67	50	50
Rider	500 Rad	82	68	55	45
Stevens	5-6,000 Rad	88	79	58	55
Mohiuddin	Preoperative + Postoperative	98	83	78	78

Category IV. Patients who are inoperable due to local extent of disease;

Category V. Patients who are inoperable due to concurrent medical illness or patients with distant metastatic disease.

Category I represents those patients with relatively small volumes of tumor, usually less than 5 cms in diameter, well differentiated or moderately well differentiated histologically, in whom the disease is accessible transrectally. These patients are candidates for transrectal surgical excision, fulguration, or endocavitary radiation therapy. The studies by Sischy, M. Parturier-Abbot, and Papillon, have indicated excellent results with transrectal endocavitary radiation therapy in over 1,200 cases.^{18,21,22,23,29,41} In patients with disease limited to the mucosa or submucosal tissues, the reported results are excellent. We recommend that patients falling in Category I be evaluated jointly by the radiation oncology and colorectal surgical services and a treatment technique be jointly agreed upon, to avoid, whenever possible, a radical surgical procedure.

Category II patients are those in whom the surgeon feels, after thorough evaluation, that an anterior resection is feasible and is the surgery of choice. In those instances we feel that preoperative radiation therapy to doses of 4,000 rad or more may significantly compromise the surgical results and may produce complication with the anastomosis or healing and may increase postoperative morbidity. In addition, the surgical approach to such patients allows "en block" resections, and pre-

Lesions below the peritoneal reflection benefit the most from preoperative treatment.

operative radiation is less necessary. An anterior resection is less likely to cause fixation of large volumes of small bowel within the pelvis and increased risk of complications with relatively high dose postoperative radiation therapy. For these reasons, we have recommended the utilization of the Jefferson "selective sandwich technique" for such patients. This consists of 500 rad whole pelvis irradiation

within 24 hours prior to surgery. This treatment does not modify the pathologic specimen and has been demonstrated to have no adverse effects on the surgical outcome. The decision for postoperative irradiation is then based upon the histopathologic findings. The presence of Stage B₂, C₁, or C₂ disease is felt to be an indication for postoperative radiation therapy. This treatment is begun approximately one month following surgery and is carried to a dose of 4,500 rad in five to six weeks with a four-field technique utilizing special shielding or field shaping as described by the Jefferson group.

High dose radiotherapy offers excellent palliation to those who are not surgical candidates.

It is our feeling that these patients are at such high risk for local and regional recurrence that the rather modest risk of radiation injury is warranted. It is our hope that postoperative radiation therapy will have a significant effect not only in increasing five-year survival but also in decreasing local and regional recurrence.

Category III patients are those in whom the surgeon feels from the initial evaluation that abdominal perineal resection will be necessary for adequate treatment. The nature of this surgical procedure leads to a greater risk of small bowel entrapment within the pelvis and thus increases the risk of radiation enteritis from high-dose postoperative radiotherapy. In addition, this procedure is less of an "en block" procedure than the anterior resection. A recent study by Rambarger et al showed that one-fourth of the 250 cases studied had a surgical perforation of the abdominal perineal resection specimen. This iatrogenic perforation led to a three-fold increase in pelvic and perineal recurrence in Stage B patients. An overall decrease in five-year survival from 46% without perforation to 31% with perforation was seen in the Stage B and C patients.²⁴

The VA studies and Rider's work, both with preoperative radiotherapy, suggest that these lesions below the peritoneal reflection and especially within 8 cms of the anus benefit the most from preoperative treatment. This treatment should be effective in Stage C disease and

Table 11. — Preoperative Treatment of Ten Patients

Pt No	Age, Sex	Radiation Therapy	Chemo-therapy	Surgery	Pathology	Status	Surv (Mo)	Remarks
1	82 M	4,500 Rad 25 RX	STD*	None	Adenoca	D	12	Free of rectal ca residual. Died of diabetic acidosis with a rising CEA.
2	61 F	4,000 Rad 25 RX	STD	Exp lap	Adenoca in liver†† No apparent rectal residual	PR	9+	Liver nodule found at laparotomy. No pretreatment liver scan. No residual rectal carcinoma.
3	66 F	4,500 Rad Ext 2,500 Rad Impl	STD	None	Adenoca	NED	12+	Refused AP resection. Developed rectal stenosis requiring colostomy. No residual tumor found
4	75 F	4,000 Rad Ext 2,400 Anal Boost	STD	None	Adenoca	NED	14+	Medically a poor surgical candidate.
5	68 M	4,500 Rad 25 RX	STD	None	Adenoca	NED	14+	Refused surgery.
6	65 F	4,320 Rad 24 RX	STD†	APR	Adenoca extended through wall. 0/2 Nodes (+)		10+	
7	61 M	4,000 Rad 25 RX	STD	APR	Adenoca extended to perirectal tissues. 2/3 Nodes (+)	NED	14+	Minor mucositis.
8	74 F	4,320 Rad 24 RX	STD†	APR	Adenoca in muscularis. 0/3 Nodes (+)	NED	13+	Leucopenia after first course chemotherapy.
9	49 M	4,140 Rad 23 RX	STD	APR	Adenoca in muscularis. 0/6 Nodes (+)	NED	8+	
10	64 F	4,000 Rad 25 RX	STD	Ant Resect	Adenoca extending to serosa. 3/8 Nodes (+)	NED	10+	Questionable sacral fixation before treatment.

*STD Chemotherapy = 5 FU 1,000 mg/m² IV (Continuous infusion) Days 1 - 4, 29 - 32
Mitomycin C 10 mg/m² IV (bolus) Day 1
†Dose Reduction, 2nd 5 FU Course. See Text.
††No Pretreatment Liver Scan.

should be especially beneficial in the case of iatrogenic perforation of the specimen in that marked tumor regression will be present, tumor cell viability damaged, and implantation, therefore, less likely to occur. We recommend that patients in Category III receive preoperative radiation therapy to the whole pelvis and perineum in a dose of 4,000 to 4,500 rad in five weeks combined with two, 96-hour continuous infusions of 5FU chemo-

therapy, 1 gm/m² body surface area IV daily during the first and last week of treatment. Surgery will be delayed four to six weeks at which time an abdominal perineal procedure will be carried out.

Category IV patients in whom surgical evaluation leads to a conclusion of inoperability due to local extension of tumor will be recommended for treatment with preoperative radiotherapy. This may or may not include

5FU infusion. It will be in the intention of the preoperative treatment to deliver no less than 4,500 and no more than 6,000 rad in five to eight weeks. In the experience of many authors, at least half of these patients may thereby be rendered resectable, and a significant number of those resected may remain disease-free for months to years.^{2,3,9,38}

Toxicity of therapy was tolerable in the vast majority of cases.

Category V patients are those found to be inoperable due to their overall poor medical status or because of distant metastatic disease. A palliative treatment program should then be planned jointly by medical oncology, radiation oncology, and colorectal surgical services. This may include surgical resection of some lesions, as well as various combinations of systemic or regional chemotherapy and local radiation therapy to obtain optimum palliation and extension of worthwhile life. In many such instances, high-dose radiotherapy with or without concurrent chemotherapy offers excellent palliation to those who are not surgical candidates. Those reporting on endocavitary radiation have noted excellent palliative results for long periods with repeat courses of treatment to tumors that are much too extensive for curative resection but in which bleeding and obstruction are recurrent problems. Our experience with this palliative technique has been most encouraging.

Our Experience

Our cumulative experience with the preoperative treatment of ten patients with localized adenocarcinoma of the rectum is presented in Table 11. Patient 2 was found to have hepatic nodularity at the completion of the second chemotherapy course; at laparotomy, hepatic metastases were proven and the planned antero-posterior resection was not completed. She is alive and with well controlled hepatic disease at 9+ months and has no evidence of persistent or recurrent rectal tumor. Eight of the nine remaining patients are alive and free of disease at intervals from

8+ to 14+ months following diagnosis. Patient 1 died 12 months after diagnosis of uncontrolled diabetic acidosis. Although the CEA had risen preterminally to 14 nanograms per ml, no evidence of residual or recurrent neoplasm was found on examination of the rectum or CT scanning of the abdomen and pelvis. The other eight patients remain free of any evidence of local or disseminated tumor although three of the eight either refused or were thought unsuitable candidates for definitive surgery. Of the five patients surgically treated (four antero-posterior resections, one anterior resection), all had evidence of muscular invasion by tumor though only two had involved lymph nodes.

Toxicity of therapy was tolerable in the vast majority of cases. Patient 6 suffered chemotherapy-induced pancytopenia and sepsis requiring hospitalization following her first course of chemotherapy, but responded to appropriate medical management. A second course of chemotherapy was given at a 25% dose reduction without difficulty. Patient 8 sustained leukopenia (WBC count 2,500) after the first course of therapy and, therefore, his second course was reduced by 40%. Patient 7 suffered minor mucositis following each course of chemotherapy which healed without incident. Patient 3 developed rectal stenosis requiring a colostomy approximately one year after treatment. No cancer was found at the time of the colostomy.

Conclusion

These results, although very preliminary and incomplete, give us some cause for optimism, especially in view of the continuous disease-free status enjoyed by the vast majority of patients and the modest toxicity which accompanied treatment. Our current treatment protocol, therefore, continues to accrue patients to be treated in this manner. A more lengthy followup on this larger group of patients will constitute the subject of a later report. □

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Preoperative Bowel Preparation

CLAUDE H. ORGAN, JR, MD

Ideal preoperative bowel preparation requires a knowledge of the intestinal flora and the mechanical and antimicrobial options available to minimize postoperative infection.

Introduction

Recent identification and quantification of bowel flora had to await the advances in microbiologic techniques that occurred in the early 1950s. Prior to this time, practicing clinicians realized that the mucosal membrane barrier of the gastrointestinal tract (GIT) prevented an unknown array of flora organisms from entering areas of the body ill-equipped to control their growth and eliminate their toxic metabolic end products. Surgeons discovered that mechanical preparation of the GIT to eliminate solid fecal matter does reduce, but not eliminate, postoperative infection. Early attempts to reduce the postoperative infection rate even further by randomly adding anti-

biotics led to worse problems due to antibiotic misuse and an era of uncertainty regarding the makeup, extent, and necessity of preoperative bowel preparation.

The GIT begins as a sterile organ in utero that becomes inoculated at its most proximal and distal ports by environmental pathogenic and nonpathogenic bacteria within hours after birth. Evolution to a normal flora requires years as the breast-fed baby (introducing *Lactobacillus*) and the bottle-fed baby (introducing complex gram negative organisms) change their diets with physical and emotional maturation.¹ Normal adult flora (Table 1) consists of an oral population of both aerobes and anaerobes with facultative aerobic streptococci and anaerobic *Bacteroides* being the common pathogens. Aerobic coliforms are prevalent in significant numbers in patients with poor dental hygiene. The unobstructed normal upper GIT, ie esophagus through upper ileum, lacks a resident flora. The resident fecal flora begins in the distal two feet of the ileum and approaches a constant colonic and fecal level at the ileocecal valve.² In the normal

colon, coliforms make up the largest group of aerobic pathogens, numbering between 10^6 and 10^8 organisms. *Escherichia*, *Proteus*, *Pseudomonas*, and *Klebsiella* species are the primary members. The anaerobic population outnumbers the aerobic population by a log factor of two to three, averaging 10^{11} organisms, and includes *Bacteroides*, *Peptostreptococcus*, *Bifidobacterium*, and *Clostridium* species.³ With specific bowel organism identification and incrimination in postoperative sepsis problems revealed by better culturing techniques, the need for a safe and effective bowel preparation became apparent to researchers and clinicians.

History

Historically, four landmark studies warrant special recognition:

1. In 1969 a double-blind randomized prospective study by Polk and Lopez-Meyer demonstrated a statistically significant decrease in wound and intra-abdominal infections during elective gastrointestinal surgery. They compared patients receiving intravenous cephaloridine and mechanical bowel preparation with patients receiving mechanical preparation only.⁴

2. Next, Nichols et al demonstrated in vivo reduction of the colonic flora utilizing short-term peroral antibiotic preparations effective against both predominant aerobes and anaerobes of the GIT in addition to mechanical preparation. Their retrospective study yielded

statistically significant differences when drug and control groups were compared.⁵

3. In 1974, in a prospective randomized double-blind fashion, Judd et al demonstrated that the use of the oral antibiotics neomycin and tetracycline in conjunction with mechanical preparation gave a statistically lower rate of wound and intra-abdominal infections problems postoperatively when compared to a mechanical-preparation-only group (and a group prepared by mechanical preparation with oral neomycine only).⁶

4. In the prospective, randomized, double-blind combined VA study, it quickly became apparent that the incidence of wound and intra-abdominal infection was reduced when a program of oral neomycin and erythromycin base combined with mechanical preparation was compared to mechanical preparation alone in identical groups of patients.⁷ Neither Judd's nor the VA's study had an incidence of staphylococcal enterocolitis in the antibiotic-treated groups.

These landmark studies demonstrate: (a) the need for appropriate antibiotic usage in addition to mechanical bowel cleansing when elective colon surgery is indicated and (b) that this approach is safe and without complications when the appropriate drugs, drug quantity, and duration of drug use are employed.⁸

Mechanical Preparation

Studies have questioned the need for mechanical preparation, if indeed antibiotics suppress the flora. Condon has stated, "Antibiotic use without mechanical preparation attacks only the surface flora of the stool, and failure to remove the core of undigested cellulose, dead bacteria, and other residue that harbor a flora nidus leaves a large inoculum of bowel flora to implant at the time of surgical intervention."⁹ The higher incidence of postoperative sepsis complications in trauma patients and in patients requiring bowel resection in the presence of obstruction stand as clinical proof that antibiotic use without mechanical preparation is less than optimal.

The ideal cleanout not only removes all evidence of solid feces but also avoids unpleasant abdominal cramping, dehydration, fatigue, and starvation, presently hallmarks of an adequate mechanical preparation. The "standard" mechanical cleanout that produces all of these side effects includes one to three days of a clear liquid diet to stop fiber input, multiple enemas

Table 1. — Flora in the Normal Adult*

Flora	Aerobic	Anaerobic
Exogenous	Staphylococci† Coliforms† Streptococci	
Oral	Streptococci (facultative) Coliforms‡	<i>Bacteroides</i> <i>oralis</i> † <i>Bacteroides</i> <i>melaninogenicus</i> †
Fecal	<i>Escherichia</i> sp, esp <i>coli</i> † <i>Proteus</i> sp <i>Pseudomonas</i> sp <i>Klebsiella</i> sp Streptococci	<i>Bacteroides</i> sp, esp <i>fragilis</i> † <i>Peptostreptococcus</i> <i>Bifidobacterium</i> <i>Clostridium</i> sp

* Data from Condon, Robert E.⁸
† Predominant organisms
‡ Found in large numbers where dental hygiene is poor

PREPARATION / Organ

to clean out leftsided, formed colonic material, and variable amounts of a cathartic to eliminate any formed material from the right colon (Table 2).

Whole Gut Lavage

In 1972 Hewitt introduced into hospital practice the Whole Gut Lavage (WGL), a research tool previously used to reproduce the cholera model for studying ion shifts.¹⁰ To produce an adequate mechanically prepped colon while reducing the side effects common with the "standard" prep, WGL is begun with noon fasting after a regular breakfast. A double lumen nasogastric (NG) tube is inserted into the stomach through which 3 to 6 liters of warm saline solution flows at an average rate of 34 to 75 cc per minute until 30 minutes following the production of clear rectal effluent. Following completion of the regimen the appropriate antimicrobials are administered by the desired route (Table 2).

The advantages of this technique over the "standard" preparation include: (1) shortened preoperative hospitalization and discomfort periods, (2) minimal starvation time, (3) improved preoperative hydration secondary to partial absorption of the irrigating fluid, and (4) depending on the rate and type of irrigant used, minimal abdominal cramping. Compelling disadvantages include the need for continuous nursing supervision during administration of the irrigant (a very costly factor), fluid and sodium retention reflected as weight gain that occurs in all patients but more significantly in those with compromised cardiovascular or renal status, the nasopharyngeal discomfort of the NG tube, and abdominal cramping that occurs in some patients no matter what precautions are taken.^{11,12}

Mannitol

Use of a 5% solution of iced, flavored, oral mannitol as the sole drug in mechanical bowel preparation is being studied by British and Australian observers. Five to six liters of the solution are consumed at a rate of 1.25 L/hr with catharsis commencing 30 to 60 minutes after ingestion begins (Table 2). In a recent study by Minervini et al, patient acceptance of this method exceeded two other methods that

Table 2. — Methods of Preparation

Mechanical

- Day 1**
1. Clear liquid diet
 2. Obtain preop lab data
 3. Castor oil, 2 fl oz at 9 AM
 4. Tap water enema, 1 liter, at 7 PM
- Day 2**
1. Clear liquid diet
 2. May begin IV early to maintain hydration state
 3. Tap water enemas until clear at 10 AM
 4. Neomycin and erythromycin (base) — 1 gm orally of each drug at 1 PM, 2 PM, and 10 PM
 5. NPO at 10 PM
 6. **

Day 3 Operation

Whole Gut Lavage (WGL)

- Day 1**
1. Regular diet
 2. Preop labs obtained either as outpatient or inpatient
- Day 2**
1. NPO after breakfast
 2. Body weight before irrigation
 3. Insert NG tube at 10 AM and begin irrigation until 30 min after rectal effluent clears
 4. *
 5. Body weight and blood chemistry (eg, SMA-7) rechecked at 7 PM
 6. Begin IV at bedtime to maintain hydration state
 7. **

Day 3 Operation

Mannitol

- Day 1**
1. Regular diet
 2. Preop labs obtained either as outpatient or inpatient
- Day 2**
1. NPO
 2. May begin IV early to maintain hydration state
 3. At 8 AM begin drinking iced, flavored mannitol 5% solution (5-6 liters) until 30 min after rectal effluent becomes clear
 4. *
 5. **

Day 3 Operation

*Neomycin and erythromycin (base) — 1 gm orally of each drug (a) at 60 min after rectal effluent clears, (b) one hour following first dose, and (c) at 10 PM

**Instead of oral antibiotics, broad spectrum IV antibiotic(s) in the appropriate dose(s) based on body weight should be given at 6 PM and 12 midnight the night before, and at 6 PM the morning of the operation. (If the operation is planned for the afternoon, readjust the time schedule of the three doses of antibiotic(s) rather than adding fourth or fifth doses of the drug.)

utilized various forms of WGL, all with comparable cleansing results.¹³ Mannitol was thought to prevent absorption and metabolism by the GI tract and effect transudation of fluid into the gut lumen to moisten stool and stimulate motility via a stretch reflex. However, studies using radioactive mannitol indicate some absorption and metabolism does occur.¹⁴ Mannitol also induces multisystem activity which resembles in part cholecystokinin-pancreozymin (CCK-PZ) hormonal activity.¹⁵

Donovan et al attempted to combat some undesirable side effects of WGL by having selected patients ingest oral mannitol solutions prior to WGL. Combining the two methods resulted in fewer cases of retained feces in patients with a history of constipation, less sodium retention, less weight gain, less lavage time, and less irrigant used when compared to the WGL-alone group.¹⁶

Elemental Diet

*Preoperative use of an elemental diet is helpful in surgical patients who are markedly malnourished, requiring two to three weeks minimum of nutritional preparation, and who do not have an obstructed GI tract.*¹⁷ Reliance on short-term elemental feedings as a means of avoiding starvation has been questioned on the basis of cost efficiency as well as therapeutic efficacy. Attempts to prove that use of elemental diet as the sole ingredient for colon preparation to suppress colonic flora and avoid postop sepsis complications have not been substantiated.¹⁸⁻²⁰

Discussion

Having chosen the mechanical prep that affords the best intraoperative bowel decompression and cleansing, the surgeon must decide on the preferred antimicrobials to use, and their route and duration of administration. *No single drug presently marketed achieves Cohn's "ideal" antimicrobial properties:* (a) effectiveness against both aerobes and anaerobes, (b) peak activity after only a single dose given 15 to 20 hours prior to operation, (c) yielding complete bowel sterilization, (d) inexpensive, (e) pleasant to take, and (f) not favoring resistant bacterial overgrowth.²¹

Commonly, two antibiotics, each effective against a single microbial spectrum, are utilized. *To control aerobes*, predominantly *E*

coli, the choice of antibiotics includes ampicillins, carbenicillin, tetracyclines, cephalosporins, and the aminoglycosides, including kanamycin, neomycin, and gentamicin. Neomycin was chosen by the Condon group because of its greater activity against the aerobes than kanamycin, poor systemic absorption which decreases the risk of resistant systemic organism overgrowth, and nonuse as treatment for postoperative infections. For controlling anaerobes, chloramphenicol, clindamycin, tetracycline, metronidazole, and erythromycin are the drugs of choice. Erythromycin in the base form was chosen by the Condon group because it (1) has the lowest amount of systemic

No single drug presently marketed achieves Cohn's "ideal" antimicrobial properties.

absorption of the drugs available, (2) has fewer resistant bacterial forms than the tetracyclines, and (3) is not chosen for use against serious postoperative infections as the other drugs might be.²² Metronidazole has an excellent anaerobic antimicrobial activity both IV and PO, and its approval for use in the US in bowel preparation is pending the results of carcinogenesis studies.²³

The possibility of in vitro resistant strains of organisms decreasing the effectiveness of an antimicrobial for use in a bowel preparation, ie, erythromycin versus tetracycline, may be a moot point. In Judd's series the statistically significant reduction of postoperative sepsis was achieved with the preop use of tetracycline that had been proven in vitro to be ineffective against 35% of anaerobic organisms present in his selected patients' colons. These results would also stand as support for Condon's statement that sterilization of the colon is not achieved with colon preparation but rather a timed critical reduction of colonic flora to a level controllable by the body's defenses if an inadvertent spill did occur intraoperatively.²⁴

If, then, the goal is to achieve critical reduction, but not total elimination of colonic flora, the dosage schedule and duration of administration should be altered and may not necessarily need to resemble therapeutic antimicrobial dosage regimens. Microbiology data have shown that microbes must be exposed to anti-

biotics for a minimum of 15 to 20 hours before a decrease in their growth curve is seen. On the other hand, the maximum amount of time the same organisms can be exposed to the drugs before resistant organisms appear is 72 hours. Therefore, to achieve peak activity levels within the allotted 20 hours, preparations such as the Condon prep use a limited number of doses of oral antibiotic grouped closely together in a bolus fashion starting at a time when motility of the bowel is slowing after mechanical preparation.²⁵ Stone has shown in a randomized double-blind prospective study that the incidence of postoperative sepsis was not decreased by extending the duration or

operative bowel preparation still holds many uncertainties, the two-part mechanical and antimicrobial bowel preparation forms the cornerstone of successful bowel surgery. □

The goal is to achieve critical reduction, not total elimination of colonic flora.

perioperative prophylactic antibiotic administration an additional five postoperative days.²⁶

Certain instances demand an alteration in the method of colon preparation. Most obvious are the patients with peritonitis secondary to trauma, toxic dilatation, or complete bowel obstruction. These patients cannot tolerate a mechanical cleanout and should be prepared with IV antibiotics started preoperatively to control both aerobes and anaerobes. Partially obstructed patients may undergo a modified mechanical preparation that includes use of clear liquids for three to seven days. A mild cathartic may be attempted on single or multiple occasions depending on patient tolerance. Patients with inflammatory bowel disease cannot tolerate cathartics or enemas; fulminant colitis or toxic dilatation could develop. Clear liquid diets should be utilized for three to five days to allow the rapid transit time common in these patients to act as a cathartic. The dose of oral antibiotic in these same patients must be extended for an additional 12 to 14 hours to compensate for the increase in transit time and resulting decrease in drug absorption.

Although the method and manner of pre-

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IV: Management of the Airway in the Newborn Infant

ROGER E. SHELDON, MD

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Prompt, atraumatic intubation of the trachea is essential for optimal neonatal resuscitation.

It is the purpose of this outline to review the steps in emergency intubation of the trachea in the newborn child — especially for the delivery room treatment of asphyxia and meconium staining.

Every physician who delivers babies should be expert in neonatal intubation; unfortunately, it is difficult to maintain this skill since most infants do not need intubation. If you feel a need for additional experience with neonatal intubation and other procedures, you may wish

to take advantage of the "Miniresidency" program offered at the Neonatal Intensive Care Unit of the Oklahoma Children's Memorial Hospital. Contact the author if you would like to inquire about this program.

I. Preparations and Equipment

- A. Be ready at all times for the possibility of an asphyxiated infant. Equipment should be checked against a checklist at least once each day, preferably once each work shift. Equipment should be kept in a sealed tray or box from which it cannot be removed without "leaving tracks."
- B. The following items should be ready:
 - 1. Oxygen — a child who needs delivery room support needs pure oxygen. Some ventilating bags must be modified to deliver 100% oxygen.
 - 2. Suction device — a DeLee trap is best and cheapest.
 - 3. Source of positive pressure — breathing bag of some kind.
 - a. Infant designs are better for babies.

- b. Those with pressure release valves are preferred.
- c. Self-inflating bags are easier to operate.
- d. Several are able to deliver nearly pure oxygen.
- 4. Heater — Kreisleman crib heaters are inadequate and their ventilating devices are unreliable, so these should be replaced with modern radiant warmers where possible.
- 5. Laryngoscope with straight blades — Miller 0 and 1.
- 6. Assorted endotracheal tubes — 2.5 to 4.0 mm.
 - a. 2.5 mm fits infants under 1,200 g.
 - b. 3.0 mm fits infants under 2,500 g.
 - c. 3.5 mm fits infants under 3,500 g and works with even larger infants.
 - d. There is no use for 2.0 mm tubes.
- 7. Drugs, needles, and syringes — rarely used.

Note: Stimulants such as coramine and caffeine are dangerous and are CONTRA-INDICATED.

II. Indications for Bag and Mask Ventilation

- A. Slow pulse (less than 100/min) after stimulation and bulb suction.
- B. Apnea.

Note: An oral airway is not required, especially if the head is positioned correctly (see below). Evidence of diaphragmatic hernia CONTRAINDICATES bag and mask ventilation.

III. Indications for Endotracheal Intubation

- A. Position the child supine with no neck extension. It may help to put a small pillow under the head, but without changing the rotational position of the head. This is called the "sniffing position," and it is the best position for both mask ventilation and intubation.
- B. Insert the laryngoscope blade to hold the tongue up and away from you and flatten the floor of the mouth. It is best not to pick up the epiglottis directly, but rather to lift

it out of the way along with the base of the tongue.

- C. Control the head and mouth with your left (laryngoscope) hand.
- D. Visualize the glottis — if you can't see it, you can't tube it.
 - 1. You may need to press on the trachea with your right hand to bring it into view.
 - 2. Some operators can press on the trachea with the left little finger throughout the procedure. Otherwise an assistant can hold this pressure for you.
 - 3. Pull up and away from yourself with the laryngoscope; do not pry or pull toward yourself.
 - 4. Pass the tube (stiffened with a stylette if necessary) between the vocal cords.
 - a. Insert the tube only one inch (2.5 cm) for any child.
 - b. Do not use great pressure — injury is easily produced.
 - c. If the tube will not pass, there is usually a malalignment between the trachea and the tube. This can be corrected by lifting or relaxing the pressure on the laryngoscope.
 - d. Rarely a smaller tube must be substituted.
 - 5. Confirm the position of the tube VISUALLY!!
 - a. To be sure the tube goes into the trachea, you must watch it go in. Breath sounds and chest movement are unreliable!!
 - b. Before removing the laryngoscope, inspect the ventral surface of the throat and base of the tongue. If you find an unexpected opening in this region, it is the trachea. You can now intubate it properly without losing further time.
 - 6. Ventilate with 100% oxygen.
 - a. Pure oxygen is needed by all infants who need ventilation.
 - b. The maximum safe pressure for the first breath is 50 cm of water.
 - c. The maximum safe pressure after the first breath is 30 cm of water.
 - d. It is wise to use a ventilating bag with a safety valve to release excess pressure. This will help prevent iatrogenic pneumothorax.

At this point, virtually all infants will recover a normal heart rate and will begin to

recover from the effects of the asphyxia. In a rare case, drugs will be needed. The proper agents and doses are beyond the scope of this article; they were included in the article by Drs Boutwell and Giacoia.¹

Many infants can be extubated in the delivery room once they have achieved a normal respiratory rate and color and have good muscle tone. If extubation is not achieved, the baby should continue to receive the necessary oxygen and pressures until he/she can be supported mechanically.

The infant who is meconium stained must have the airway suctioned BEFORE the first breath if possible. Therefore, the individual who intubates the baby must be aware of the meconium staining and alter the procedure ac-

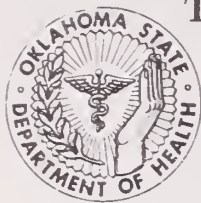
cordingly. The next article in this series will detail the approach to the meconium-stained infant. □

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News From The Oklahoma State Department of Health

In recent months, 20 cases of active tuberculosis have been identified among students at Oklahoma colleges and universities. Concern over this increase of active cases and the excessive number of contacts with these cases (over 2,500 at one institution and 300 at another) prompted a joint effort of the state health department's Tuberculosis and Respiratory Disease Division and collegiate medical units to reverse this trend.

Epidemiological investigation revealed that foreign-born students accounted for 90 percent of these active cases, disclosing the distinct possibility that they were also the source cases for the other 10 percent. Discussions with the collegiate medical units and other health agencies showed that foreign-born students are not required to have TB testing prior to entering the United States or being admitted to Oklahoma universities. For these reasons, TB

screening was concentrated among this population.

To date, skin testing has resulted in a 25 percent positivity rate in foreign-born students (the normal rate is 10 percent per selected population). A portion of this high positivity rate may be attributable to the large percentage of this group with a history of BCG (bacillus of Calmette and Guérin) vaccination which can cause a positive reaction to the skin test; however, nearly as many students with a history of BCG vaccination did *not* have a positive skin test reaction. Current research reflects doubt about the efficacy of BCG and recommends treatment of these persons with near total disregard of their BCG status.

In view of the Tuberculosis and Respiratory Disease Division's findings, private practitioners and clinics who examine or treat foreign-born college students should be aware of the prevalence of TB among this group and act accordingly. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR AUGUST 1983

Disease	August 1983	August 1982	July 1983	Total to Date	
				1983	1982
Amebiasis	3	1	—	7	10
Aseptic Meningitis	73	13	94	255	79
Brucellosis	1	—	1	5	4
Encephalitis, Infectious	7	3	7	25	19
Gonorrhea (Use Form ODH-228)	1,488	1,303	1,171	10,484	10,560
Hepatitis A	58	55	50	340	475
Hepatitis B	36	34	34	216	223
Hepatitis Unspecified	19	16	27	163	171
Malaria	—	1	—	7	7
Measles (rubeola)	—	21	—	1	21
Meningococcal infections	—	—	2	25	22
Pertussis	74	2	61	205	5
Rabies (animal)	7	14	9	90	146
Rocky Mountain Spotted Fever	33	9	81	189	76
Rubella	—	—	—	—	3
Salmonellosis	63	56	72	347	242
Shigellosis	30	49	22	137	234
Syphilis (Use Form ODH-228)	17	11	16	160	129
Tetanus	—	—	—	—	1
Tuberculosis	40	19	—	166	253
Tularemia	4	3	6	22	22
Typhoid Fever	—	—	2	3	2

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The Southwestern Metabolism and Diabetes Center on the Saint Francis Hospital medical campus in Tulsa conducts comprehensive, medically supervised programs for adults, pediatric and teenage patients with metabolic dysfunction.

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The Southwestern Metabolism and Diabetes Center's weight-control programs require the active participation of all patients in the medical rehabilitative process. These programs should be considered the equivalent of supervised in-hospital programs for patients with chronic diseases or medically-supervised physical fitness programs for healthy individuals.

The Southwestern Metabolism and Diabetes Center's facility allows patients to prepare meals and learn calorie-control techniques in individual laboratory kitchens. Periodic physical examination and biochemical testing monitor a patient's medical condition and documents improvement in specific physiologic function. Certified school teachers help school children continue their lessons in a classroom setting.

Although participants will have the opportunity to stay at new luxury hotel facilities near the hospital or in an inpatient metabolic treatment unit and will be educated in a recently-constructed, modern medical facility, these weight-control programs are not intended to represent a "health spa" or vacation retreat. They are designed to produce a significant improvement in the health status and fitness of each participant. A commitment of time and activity is necessary to produce these important results.

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Earlier verdict against Bendectin reversed in favor of manufacturer

Judge Joseph M. Hannon of the Superior Court of the District of Columbia recently ordered a verdict in favor of Merrell Dow in a case alleging its drug Bendectin was responsible for birth defects in a 12-year-old child, Mary Oxendine.

This order reverses an earlier jury verdict in favor of the Oxendine child which awarded \$750,000 in compensatory damages. In addition to negating the earlier jury verdict, the judge's verdict eliminates another trial for punitive damages which was to have followed.

In the court order dated September 1, 1983, Judge Hannon stated: "In support of her (Oxendine) case to establish proximate cause, Plaintiff relies on four principal grounds. The first is the structural activity of Bendectin which included an antihistaminic component, together with the awareness that certain antihistamines have been determined to be teratogenic in certain animals. Plaintiff also relies on the animal or in vivo studies. The third ground involves the in vitro studies performed at the National Institutes of Health. Finally, Plaintiff relies on human epidemiologic data.

"It is clear to the court from a review of the evidence adduced at the trial of this action that no conclusion one way or another can be drawn from any of the above relied upon bases respecting whether Bendectin is a human teratogen. And it is also clear from the evidence that Plaintiff has failed to prove that use of Bendectin by her mother proximately caused her birth defect."

With this ruling Merrell Dow has successfully defended the two cases to reach trial to date alleging Bendectin caused birth defects in children born to mothers who used the drug for nausea and vomiting of pregnancy.

In the other, the *Mekdeci* case, on August 15, 1983, the US Court of Appeals upheld a 1981 verdict in favor of the company.

Production of Bendectin, the only US approved drug for treating nausea and vomiting of pregnancy, was discontinued by Merrell Dow on June 9, 1983, for business reasons. The company has steadily maintained that Bendectin was safe and effective, however. The costs of defending the drug and the drain on company resources were cited as reasons for the decision. □

ASIM distributes belt-tightening plan for hospital medical staffs

The American Society of Internal Medicine (ASIM) has designed and distributed to approximately 2,000 of the nation's largest hospitals a step-by-step project to get hospital medical staff involved in holding down costs. Methods include exhibiting greater cost-consciousness, coordination, and less duplication when ordering various tests and procedures.

Called the "Ancillary Services Cost Containment Project," its objective is to avoid random restrictions or reductions in hospital services by increasing awareness and communication among hospital medical staff about costs and unnecessary uses of ancillary services — an area of hospital services that *can* be reduced without adversely affecting patient care. Project guidelines recommend the creation of a committee to implement voluntary procedures such as flagging duplicate test orders and printing the prices of services on all order forms.

This is the second such project to reduce costs in the hospital setting that the Society has developed and distributed. The first, in 1981, was designed to help reduce costs through the implementation of competitive bidding procedures for drug purchases. Both projects are outgrowths of ASIM's participation in two consecutive Cost Effectiveness Conferences sponsored for medical specialty societies by the American Medical Association (AMA). □



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AMA issues background statement on controversial "Baby Doe" rule

The American Medical Association (AMA) has released the following statement of the AMA to the Department of Health and Human Services regarding "Nondiscrimination on the Basis of Handicap Related to Health Care for Handicapped Infants," as published in the *Federal Register* of July 7, 1983 (48FR30846).

Background: The Department of Health and Human Services (HHS) proposes to modify the procedures for handling alleged violations of Section 504 of the Rehabilitation Act of 1973. This section prohibits discrimination against handicapped persons by recipients of "federal financial assistance."

The proposed rule would require such recipients to post this notice — "Discriminatory failure to feed and care for handicapped infants in this facility is prohibited by federal law" — with a "hotline" telephone number in each part of a facility that may have any responsibility for care of newborns. The notice would also state that "Any person having knowledge that a handicapped infant is being discriminatorily denied food to customary medical care should immediately contact" HHS. The rule would allow government investigators to have 24-hour access to the patient records and facilities of such institutions.

The proposed rule would also require state child protective service agencies that receive federal financial assistance to establish a mechanism for promptly dealing with reports of medical neglect of "handicapped" infants. This process would require that hospitals, physicians, nurses and other personnel, in ac-

cordance with state laws, report such cases to the state agency and the agency notify federal authorities. The state agency also would have to review the reports, conduct on-site investigations, and seek court orders to compel parents and physicians to provide "necessary nourishment and medical treatment."

AMA Policy: The American Medical Association believes the proposed rule is an inappropriate intrusion by the federal government into an area best left to families, physicians, and community leaders. The federal government can contribute significantly to those having to make these difficult decisions if, instead, it encourages dissemination of reliable information concerning up-to-date methods for treating severely deformed newborns and if it helps to improve support systems and other community resources that could assist parents in caring for handicapped infants.

The American Medical Association objects to the proposed rule for the following reasons:

Justification for the Rule

- Federal agencies should focus their efforts upon determining the actual extent of severe impairment in newborns; explore the issues involved in their treatment; assess the availability of facilities and resources and the capacity of voluntary and state agencies to provide assistance; and evaluate such factors as impact of various options on the families of the severely handicapped newborn, confidentiality of the physician/patient relationship, and malpractice and disciplinary risks faced by health care providers.

(continued on next page)

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Effect on Families and Institutions

- The posted notice could increase the fears of expectant parents and create distrust of physicians and hospital personnel.
- Some individuals might perceive that the notice is posted to remedy prior improper actions of the facility.
- The rule provides no protection to families and physicians or institutions against frivolous and unjustified complaints by persons who may not be in a position to determine whether appropriate care is being given.

Liabilities of 24-Hour Access by Government Investigators

- The proposed rule does not clarify what circumstances warrant immediate access.
- Investigators without medical training may not be able to interpret records or the medical situation properly.
- The privacy of patients' medical records may not be protected.
- Giving investigators 24-hour access to hospital facilities and records could result in delayed treatment for some patients whose charts and orders are removed from the treatment area.

Ethics Committees

- Ethics review bodies should be established voluntarily by local hospitals and their medical staffs to assist parents, physicians, and other members of the treatment team in decision making. Use of ethical review boards to assist in enforcement of the proposed rule would create an adversarial atmosphere rather than provide an open forum for sharing information and views.

Congressional Intent

- Congress did not intend Section 504 to be used to mandate medical treatment decisions or to require physicians or hospital administrators to override parental decisions regarding medical and surgical treatment of their children. The intent of Congress in enacting Section 504 was to provide the handicapped with access to education, employment, facilities, and programs on the same basis as nonhandicapped individuals.
- The threat of penalties (termination of all federal financial assistance) may encourage physicians and hospitals to end participation in federally funded programs, par-

ticularly those supporting specialized treatment facilities for the newborn. Neonatal care units might be shut down to avoid the risk of losing federal funds, eg Medicare, essential to maintaining patient services provided by the institution.

Conclusion: The American Medical Association believes that federal agencies, including the Department of Health and Human Services, should focus their attention on improving public education and disseminating information concerning the prognosis for severely deformed infants and on providing parents with information concerning community resources available for assistance in caring for such children. □

Medical school applications and first-year enrollments decline

For the first time in 17 years, enrollment of first-year medical students has decreased, according to a recent issue of the *Journal of the American Medical Association (JAMA)*. The 1982-1983 reduction, down 90 students from the previous year's enrollment, is partly due to cutbacks of medical school subsidies by states and also to some medical schools switching from three- to four-year programs.

The September 23/30 issue of *JAMA* is devoted to a survey of medical education in the United States, the 83rd such annual report. Among the highlights is a report on undergraduate medical education prepared by Anne E. Crowley, PhD; Sylvia Ietzel; and Edward S. Petersen, MD. They say that the number of medical school applicants in 1982-1983 also decreased by 1,000 (2.7%), compared to the previous year — a trend that is likely to continue throughout the decade, Petersen adds. There simply are fewer 22-year-olds in the population, he says.

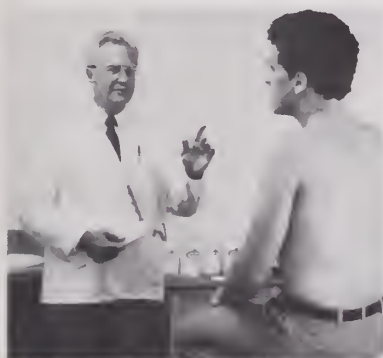
Overall, however, "the numbers of full-time faculty and of medical students in US medical schools continued to increase," the report says. "There were 66,886 medical students enrolled in 127 medical schools in the 1982-1983 academic year. This represents an increase of less than one percent over the preceding year."

Higher numbers of women medical students, 19,627 versus 18,555, represented another identified trend. The women experienced a 1.4% increase in student enrollment, to 19,627 or 29.3% of total students enrolled. □

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Physicians' prescribing practices improve with counseling from peers

When doctors are counseled by other physicians to reassess their drug prescribing habits, patients benefit both physically and financially.

So says William Schaffner, MD, and colleagues who report in a recent issue of the *Journal of the American Medical Association (JAMA)* that Tennessee physicians reduced their prescription writing practices by 50% for certain antibiotics after physician peers warned of potentially adverse side effects.

The Vanderbilt University researchers also report, however, that neither mailed brochures nor visiting pharmacists, armed with the same information, caused the practitioners to change their prescribing habits.

"This study demonstrates that a nonpunitive, educational program sponsored by the medical profession can change patterns of office practice that are inappropriate or excessively costly," say the researchers. "The challenge to the profession is whether it chooses to promote educational programs that correct excesses of medical practice or whether to leave such controls to others."

That practicing physicians were so receptive to nonbiased recommendations made by their peers illustrates the "need and desire of practicing physicians for a relevant, convenient, and unbiased source of accurate prescribing information," writes Jerry Avorn, MD, of Harvard Medical School, in an accompanying editorial.

Part of the prescription problem stems from the fact that medical school pharmacology courses are "rather brief to begin with," says Avorn. "For most physicians, subsequent drug education is heavily dominated by the promotional efforts of the pharmaceutical industry. So sophisticated and effective are these efforts that it is easy to forget that their main purpose is to increase product sales."

Avorn suggests, pending other prescription studies, that a clinical science-based, noncommercial "detail person" become commonplace

in order to provide physicians with a continuing source of drug prescription information. □

Medicaid claim process clarified

"Clean claims" for Medicaid were explained recently by Robert Fulton, Director of the Oklahoma Department of Human Services (DHS).

In a letter to David Bickham, Executive Director of the Oklahoma State Medical Association (OSMA), Fulton said that a clean claim is defined in the Federal Regulations as being a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

The definition includes a claim with errors originating in a State claims system, but does not include a claim from a provider who is under investigation for fraud or abuse or a claim under review for medical necessity.

Fulton went on to say that major reasons why claims are not clean include incorrect case numbers, lack of proper eligibility information, inadequate patient identification, and improper vendor identification.

Some claims are clean but still may be suspended or delayed from payment because they raise questions about utilization, involve possible duplicate claims, or are for patients who are in "always audit" status, Fulton continued.

Accurate completion of DHS form 1500 in accordance with the instructions issued July 6, 1983, will ensure timely processing of claims. □

DHS requires form 1500 for Medicaid

Physicians should note that the Oklahoma Department of Human Services (DHS) has modified the Medicaid regulations for the payment of patient services to hospital-based physicians who do not bill the patient directly.

Retroactive to April 1, a DHS form 1500 identifying the services rendered must be filed with the department. Payment will be made in the physician's name but can be mailed to and negotiated by an agent of the physician, ie hospital, if an approved contract is on file with the department. The new payment process does not change the reimbursement formula.

The DHS is developing a special form for the agency relationship.

Physicians who contract with more than one hospital may use multiple addresses; more than ten addresses will require special arrangements. □

OSMA ANNUAL MEETING

Shangri-La, Afton, Oklahoma

May 9-12, 1984

Umbrella policy being offered as personal liability "best buy"

At a time when liability lawsuits are on the upswing generally, the OSMA-sponsored Personal Umbrella Liability Program continues offering broad coverage at low rates to association members.

A "personal liability" umbrella policy significantly increases the limits of protection above the personal liability coverages found in homeowners policies, automobile policies, watercraft policies, some incidental business properties, and employer's liability for farm employees. "Personal liability" involves claims which arise from injury to a person or damage to another person's property.

A personal umbrella policy does not apply to professional negligence.

The OSMA policy is available through C.L. Frates and Company, the insurance agency which manages the Physicians Liability Insurance Company (PLICO); the coverage is underwritten by United States Fire Insurance Company.

All new and renewal certificates issued under the OSMA program commence on January 1. Those physicians wishing to enter the program after that date can be provided certificates expiring the following January 1. The premium for such short-term certificates is prorated for the actual number of days coverage is provided. The 1984 program is geared to accommodate a broad range of limits running from \$1,000,000 through \$10,000,000.

The "basic" Personal Umbrella Liability Policy under the OSMA group plan costs \$60 annually for \$1,000,000 in additional protection for the following risks and their respective required underlying coverages:

Primary residence (required underlying coverage of \$100,000);

Two automobiles (required underlying coverages are \$100,000 per person, \$300,000 per accident, and \$50,000 property damage).

Additional automobiles (over two) require only \$10 more annual premium each.

OSMA's reduced group premium rates for this protection cannot be matched through an individually rated policy, according to the Frates agency. Moreover, the umbrella approach is an inexpensive way for a physician to

obtain the high limits necessary to achieve comfortable security against the personal liability risk.

For more information about the Personal Umbrella Liability Program of the OSMA, a physician may contact C.L. Frates and Company directly or may work through a local agent of choice. □

Book Review

Indian Heritage, Indian Pride, by Jimalee Burton, Norman: University of Oklahoma Press, 1981. Pages 176 with 30 color illustrations. Price not given.

A review of this book should properly begin with information about the author. She was one of three daughters of Cherokee parents, who grew up in the vicinity of a trading post in western Oklahoma, at a time when there was an interface of the white and Indian races. Hence, she had ample opportunity to observe, at close range, much about the customs and life styles of each race. She later advanced her education at the university level and traveled to many areas that were once sites of great Indian civilizations in prehistoric ages. In these places she learned still more about ancient Indian cultures, legend, lore, arts, crafts, etc. All these experiences have made her eminently qualified to write with authority about the subject she has chosen for this book.

What William Wordsworth said about poetry can be said about this book, ie, it is "a spontaneous overflow of powerful feeling," or it might be compared to a piece of cloth, woven to depict the totality of Indian culture, and has running through it and interwoven within it many kinds of brilliant threads which reveal the many facets of Indian heritage and pride, including such things as art, agriculture, architecture, crafts, ecology and the Indian's reverence for nature, foods, medicines, morality, religion, stories of relations between the white man and the Indian, poems and color illustrations, with explanations of the fascinating symbolism in these illustrations.

The interesting and fascinating material, her fluent style of writing, and her commanding authority over the broad scope of knowledge about this segment of the human race, all have such a captivating effect on the reader that he will repeatedly find himself saying,

"still one more chapter before I stop." At no point is there a place in the book where one would be willing to pause to take care of some other matter that might seem more urgent at the moment.

In Rotary there is what is known as the 4-Way Test, which is an excellent guideline for checking on the ethical propriety of one's behavior. The test consists of four simple questions, as follows:

1. Is it the truth?
2. Is it fair to all concerned?
3. Will it build good will and better friendship?
4. Will it be beneficial to all concerned?

When one reads this book and keeps this test in mind, one gets a strong opinion that one affirmative answer out of a possible four is entirely unsatisfactory. One also gets the idea that both races (to again quote Wordsworth) have "thoughts that lie too deep for tears," viz, the white man, because his predecessors have so flagrantly exploited and interrupted the heritage and pride of a noble race of people; and the Indian, he realizes that he will never again be able to return with pride to what was once his cherished and noble heritage.

Luke L. Ellenburg, MD
1203 Dogwood Drive
Greeneville, Tennessee 37743

In Memoriam

1982

<i>Hugh C. Graham, Sr, MD</i>	<i>November 11</i>
<i>John David Wilson, MD</i>	<i>November 11</i>
<i>Clinton Gallaher, MD</i>	<i>November 15</i>
<i>Bert F. Keltz, MD</i>	<i>November 30</i>
<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

<i>Dewey K. Rhea, MD</i>	<i>January 3</i>
<i>Fred C. Buffington, MD</i>	<i>January 4</i>
<i>C.D. Cunningham, MD</i>	<i>January 26</i>
<i>William S. Jacobs, MD</i>	<i>February 9</i>
<i>John R. Little, MD</i>	<i>February 11</i>
<i>L.A.S. Johnston, MD</i>	<i>February 16</i>
<i>Selwyn A. Willis, MD</i>	<i>March 3</i>
<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
<i>George M. Adams, MD</i>	<i>May 3</i>
<i>John R. Reid, Jr, MD</i>	<i>June 14</i>
<i>Gilbert E. Haslam, Jr, MD</i>	<i>June 15</i>
<i>Thomas A. Trow, MD</i>	<i>June 23</i>
<i>Richard D. Mullett, MD</i>	<i>June 28</i>
<i>Aaron C. Little, MD</i>	<i>July 1</i>
<i>Michael C. Manning, MD</i>	<i>July 3</i>
<i>Hillard E. Denyer, MD</i>	<i>August 8</i>
<i>Edward A. Allgood, MD</i>	<i>August 18</i>
<i>Hugh E. Wilson III, MD</i>	<i>August 27</i>
<i>Harold J. Black, MD</i>	<i>September 1</i>

Death

HAROLD J. BLACK, MD
1900 - 1983

Harold J. Black, MD, retired Tulsa surgeon, died September 1. Born in Moulton, Iowa, Dr Black earned his medical degree at State University of Iowa College of Medicine in 1925. He moved to Tulsa in 1929 and practiced there until his retirement in 1977. Dr Black was Chief of Staff at Hillcrest Medical Center in 1954 and also served as Chairman of the Hillcrest Board of Governors in 1962-1963. He was a Fellow of the International College of Surgeons and was awarded a Life Membership in the OSMA in 1971.

Miscellaneous Advertisements

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


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The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used IV: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly IV, it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, i.e., phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or over-sedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity,

insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: Adults: Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.) For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children administer I.V. slowly; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly; repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, IV fluids, adequate airway. Use levaterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.



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*Committee on Dietary Allowances, National Research Council:
Recommended Dietary Allowances, ed. 9. Washington, DC, National
Academy of Sciences, 1980, p. 13.

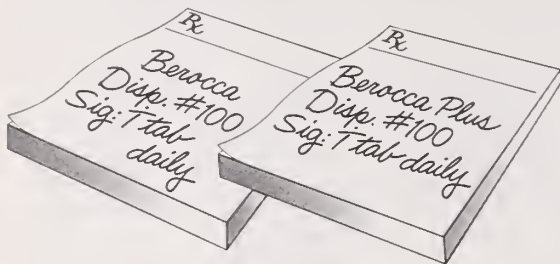
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INDICATIONS: Berocca—Supportive nutritional supplementation in which water-soluble vitamins are required prophylactically or therapeutically, including conditions causing depletion or reduced absorption or bioavailability of water-soluble vitamins; conditions resulting in increased needs for water-soluble vitamins. Berocca Plus—Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion or reduced absorption or bioavailability of essential vitamins and minerals, certain conditions resulting from severe B-vitamin or ascorbic acid deficiency, or conditions resulting in increased needs for essential vitamins and minerals.

CONTRAINDICATIONS: Hypersensitivity to any component. **WARNINGS:** Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inadequately treated with B₁₂.

PRECAUTIONS: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, vitamin D and calcium supplementation may be required with Berocca Plus or supplementation with fat-soluble vitamins and minerals may be required with Berocca. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with in judicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease efficacy of levodopa in treatment of parkinsonism. Not recommended for patients undergoing such therapy.

ADVERSE REACTIONS: Have been reported with specific vitamins and minerals, but generally at levels substantially higher than those in Berocca and Berocca Plus. Allergic and idiosyncratic reactions are possible at lower levels. Iron, even at recommended levels, has been associated with GI intolerance in some patients.

DOSAGE AND ADMINISTRATION: Usual adult dosage: one tablet daily. Available on prescription only. Berocca Plus is not recommended for children.

HOW SUPPLIED: Berocca—Light green, capsule-shaped tablets—bottles of 100 and 500. Berocca Plus—Golden yellow, capsule-shaped tablets—bottles of 100.

RU-TUSS[®] II

sustained release capsules

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage In pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated patient, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

HOW SUPPLIED: Green and clear capsules with green and white beads. Bottles of 100 tablets. NDC 0524-0031-01.

Store at controlled room temperature 15-30°C (59°-86°F.).

CAUTION: Federal law prohibits dispensing without prescription.

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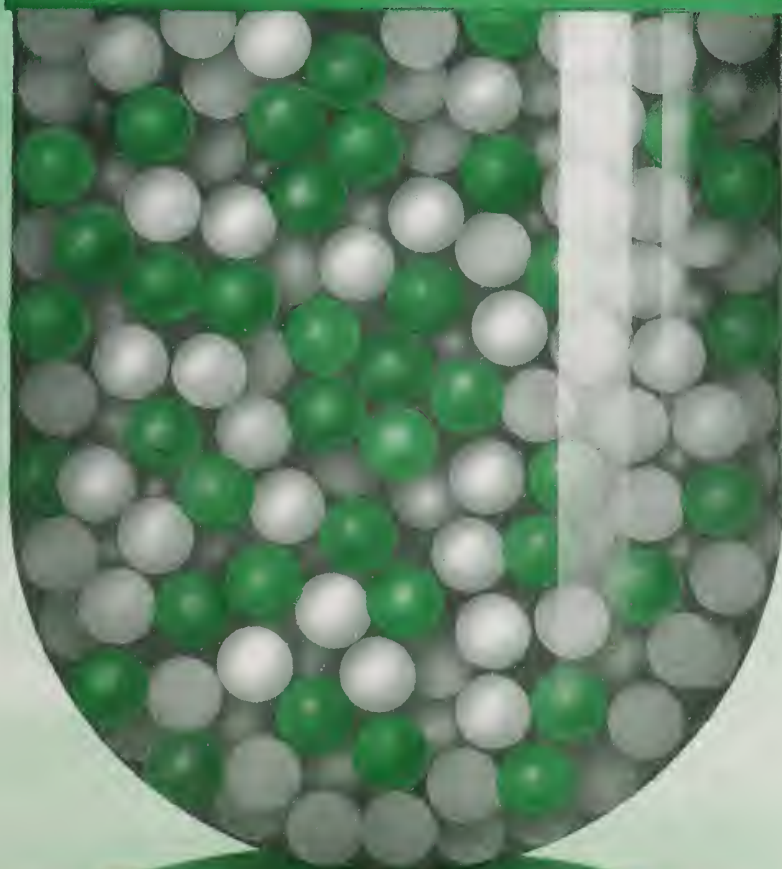
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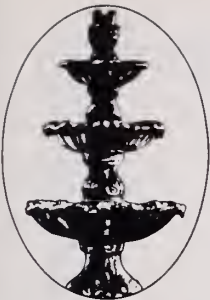
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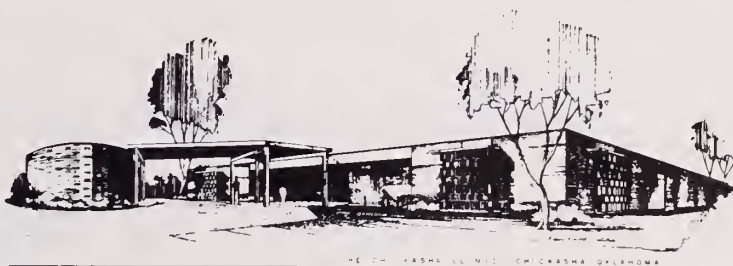
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The purposes of the conferences are 1) to focus attention of physicians and community leaders and organizations on the serious developmental and health problems faced by children and adolescents, and 2) to focus attention on the great and often unrealized potential that physicians have to assist individuals and communities in the prevention and treatment of problems of development and lifestyle.



We all went to the conference as a group of investors worried about our long term dividends. We shared concern about the most important investment a nation makes: The future of its children and youth. We fear for their healthy development, both now and in the future. And, because they are our future, we must harbor fears about our nation itself.

We believe in an America where children's chances to survive, develop, learn, and thrive do not depend entirely on the wealth of the family into which they are born or the generosity of its neighbors. We believe that all children ought to have the essentials — food, shelter, and health care — not only because it is morally right but because the future of free democratic institutions depend on it.

Great concern that we are not investing wisely in our children's future is not without foundation:

1) Infant mortality rates are rising in our cities. Rates in some census tracts are higher than in Honduras, the poorest nation in Central America.

2) Immunization rates for preschoolers have gone down each year since 1978. Over half of inner city and minority children get no DPT and no polio immunization.

3) Hunger is increasing in America again, and there is an increase in growth failure among small children.

4) One pregnant mother in twenty gets little or no prenatal care.

5) Each year over 1,000,000 children are abused; 1,000 die due to severe abuse.

6) Some 500,000 children have been separated from their families and live in foster homes.

7) Over 6,000,000 children under the age of 13 receive no day care while their mothers work.

8) Over a million adolescents and children run away each year, and the majority of male and female prostitutes are runaways.

9) Smoking among teenagers is reportedly at an all-time high, and numerous communities face the problem of teenage alcoholism.

The concept of "lifestyles" incorporates the notion of free choice, the idea that personal and social behavior is somehow rooted in the decisions of indi-

viduals. If it is all this simple, we will not begin to remedy the problems which concern us. We will end up blaming *the victim*, the very person about whom we are so concerned. Rather than ask what that runaway girl was doing on the street, we will instead ask about factors causing adolescents to run. We will ask why the pregnant mother neglected prenatal care rather than inquiring why thousands like her cannot get it. We will ask why some parents *abuse* their children, rather than asking about the economic stresses which cause otherwise decent people to hurt those they love.

What does the term "lifestyle" really mean to those of us concerned about our children and youth? Lifestyle means the way we live. It means more mothers having to work today. It means changes in the family, less extended family support, changes in diet, greater stress, more susceptibility to forces like advertising, television, alcohol, and drugs.

We must be in favor of economic and fiscal policies that are fair, and which put mothers and fathers to work. It means opposing government policies to control inflation which puts adults out of work, with their children the silent victims.

Do we really believe that additional bombs and missiles to defend our land are more important than defense of babies and mothers? Isn't there something terribly wrong when a nation has money for arms, but not enough to immunize its children?

In 1982, the administration proposed cutting \$11 billion in child and family programs. This year, another \$3.5 billion was proposed. This means a loss of one of every six dollars spent on the poorest and most high risk children in America. No other group has been made to sacrifice so much to control so little of the federal deficit.

These cuts and the priorities they reflect hurt children. Dr Jean Mayer, the noted nutritionist and President of Tufts University, said "Of all the dumb ways to save money, not feeding kids is the dumbest." Since 1980, 2.5 million more children have fallen into poverty as the result of federal policy and program changes. We simply cannot afford to ignore the tragic consequences of federal policies and priorities which jeopardize our youngsters.

Bobby Kennedy once said of the Gross National Product: "It does not include the beauty of our poetry or the strength of our marriages, the intelligence of our public debate or the integrity of our public officials. It allows neither for the justice in our courts, nor the justice in our dealings with one another. The Gross National Product measures neither our wit nor our courage, neither our wisdom nor our learning, neither our compassion nor our devotion to country. It measures everything, in short, except that which makes life worthwhile."

— Mrs Munson (Vaughn) Fuller

A photograph taken by Dr Leon Horowitz, Tulsa allergist, was selected for the cover of the entry forms for the 1983 Tulsa Run held Saturday, October 29 in Tulsa. The photograph, chosen by the *Tulsa World*, was also used for the race's promotional poster. Dr Horowitz took the picture at last year's Tulsa Run and in May entered it in the photography contest at the OSMA Annual Meeting, where it was on display for several days.

The Oklahoma Medical Group Management Association (OMGMA) will meet Thursday and Friday, December 1 and 2, at the Bank of Oklahoma in Tulsa. Attendance is open to all interested persons and offers an opportunity to meet with managers from across the state. For details, call or write Benita Bradley, President, OMGMA, PO Box 52588, Tulsa, OK 74152, (918) 749-2261.

Free serum testosterone appears to be linked to acne in women, reports a group of researchers at Emory University School of Medicine in Atlanta. They have found in one group of women that those with acne had almost twice as much free testosterone in their bodies as a control group of women without acne. They also found that among women with acne, 46% had elevated free testosterone even though total testosterone was elevated only 16%. The findings may provide a more rational basis for corrective hormonal treatment of acne, the researchers say.

Patient waiting time in physicians' offices can be reduced, report Judy Ann Bigby, MD, and colleagues from Harvard Medical School. In their study they found that letter and telephone appointment reminders reduced the "no show" rate for patients by 14% to 24% in a four-week period. With fewer unkept appointments, they say, the need for compensatory overbooking decreases — and patient waiting time may decrease as well.

Suicide pacts are not always a situation in which two people mutually agree to act, writes Milton Rosenbaum, MD, in a recent issue of *Archives of General Psychiatry*. In interviews with survivors of such pacts, he has learned that pressure is often used by the instigator to convince the partner to comply. This suggests a homicidal component in suicide pacts, according to Rosenbaum. Since instigators in suicide pacts are more likely to be male partners who are severely depressed, physicians should evaluate their depressed male patients for "murder risk" as well as "suicide risk," he advises.

A proposed Food and Drug Administration (FDA) rule would clarify that a physician may prescribe an approved drug for uses not included in the drug's approved labeling. Once a drug has been approved for marketing, a physician may prescribe it for a nonapproved purpose in treating patients. The FDA's announced policy goals in issuing the proposal are to encourage innovation by narrowing the scope of regulation.

Three cases of toxic shock syndrome (TSS), all in men, are reported in a recent *Archives of Otolaryngology*. They are part of an increasing number of TSS cases associated with surgical wounds, say physicians from UCLA and the New Mexico Health and Environment Department. In the three cases being discussed, TSS developed as a complication of *Staphylococcus aureus* bacterial overgrowth on nasal packing. In the reports, nasal packing to control bleeding is likened to the use of a tampon during menstruation.

Refusal of treatment by patients is a common occurrence in hospitals, according to Paul S. Appelbaum, MD, and Loren H. Roth, MD, from the University of Pittsburgh School of Medicine. They report that failure of communication and trust between patient and physician is an important contributing factor. A third of the patients in the study never received the refused treatment, and another third — mostly incompetent patients — were either forced to have treatment or received substitute treatment. The patients who ultimately complied with their physicians' advice did so more often than not out of guilt for having embarrassed or expressed anger at the physician, the authors say.

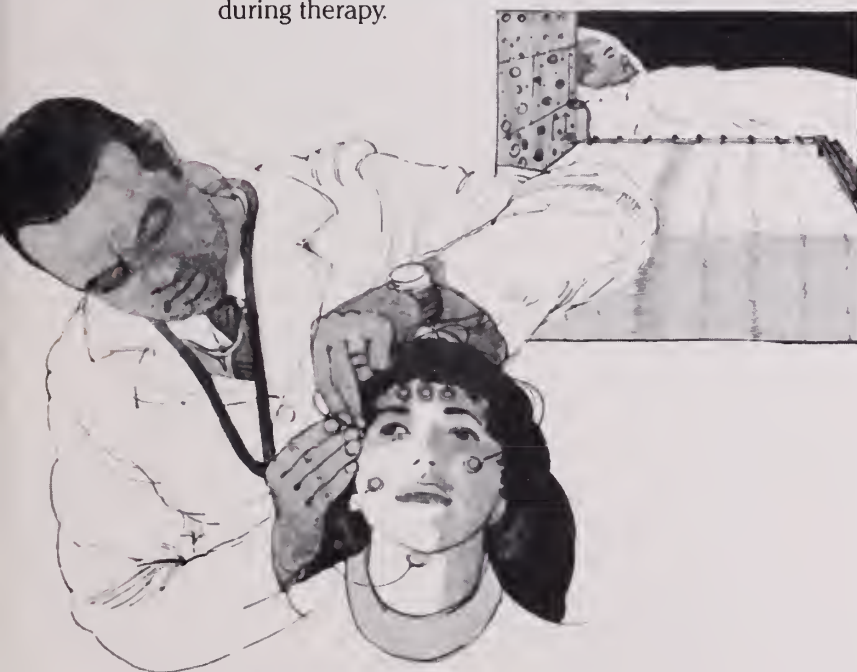
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. **Adults:** 30 mg usual dosage; 15 mg may suffice in some patients. **Elderly or debilitated patients:** 15 mg recommended initially until response is determined.

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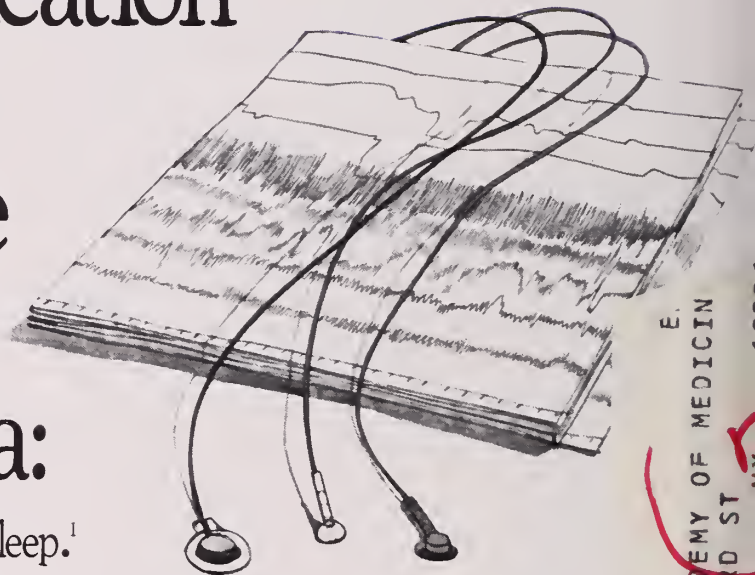
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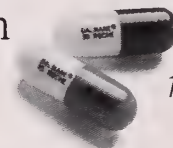
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S. pneumoniae

Brief Summary Consult the package literature for prescribing information

Indications and Usage. Ceclor® (cefadroxil, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings. IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of *Clostridia*. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions.—If an allergic reaction to Ceclor occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents (e.g., pressor amines, antihistamines, or corticosteroids).

Prolonged use of Ceclor may result in the overgrowth of "nonsusceptible organisms." Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® Glucose Enzymatic Test Strip (USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy.—Pregnancy Category B.—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers.—Small amounts of Ceclor have been detected in mother's milk following administration of single 500 mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

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cefadroxil

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hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor® (cefadroxil, Lilly) is administered to a nursing woman.

Usage in Children.—Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia, and frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported; half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain.—Transient abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic.—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic.—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal.—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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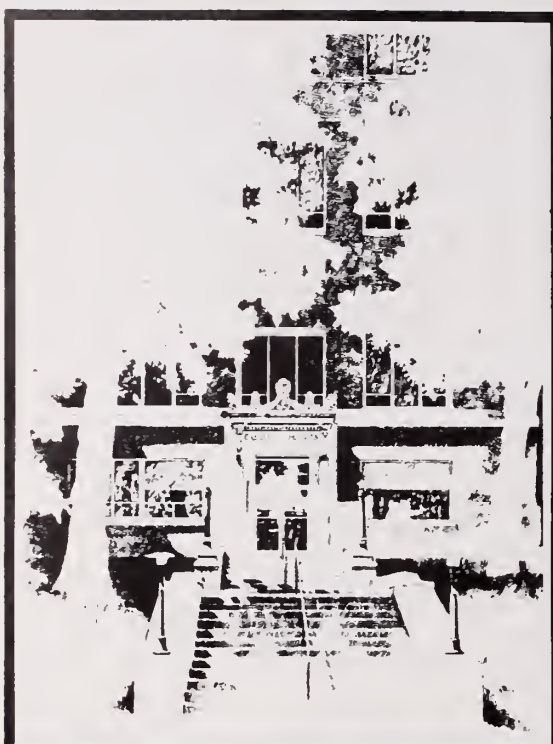
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**sustained release
capsules**

Before prescribing, see complete prescribing information. The following is a brief summary.

DESCRIPTION: Each sustained release capsule contains 12 mg of Chlorpheniramine Maleate, USP and 75 mg of Phenylpropanolamine Hydrochloride, USP in a base to provide prolonged activity.

INDICATIONS: For the treatment of the symptoms of seasonal and perennial allergic rhinitis and vasomotor rhinitis, including nasal obstruction (congestion).

CONTRAINDICATIONS: Hypersensitivity to any of the components, concurrent MAO inhibitor therapy, severe hypertension, bronchial asthma, coronary artery disease, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction. Do not use in children under 12 years.

Do not use this drug in patients with narrow-angle glaucoma, obstructive or paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. Do not use in nursing mothers.

Use in treating lower respiratory tract symptoms, including asthma, is contraindicated.

WARNINGS: Caution patients about activities requiring alertness (e.g., operating vehicles or machinery). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients. Patients should also be warned about the possible additive effects of alcohol and other CNS depressants.

Usage in pregnancy: Safe use in pregnancy has not been established. Use only when the potential benefits have been weighed against the possible hazards to the mother and child. Note that an inhibitory effect on lactation may occur.

PRECAUTIONS: Use with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension, hiatal hernia with reflux esophagitis, intestinal atony of the elderly or debilitated intestinal obstruction, myasthenia gravis, renal function impairment, and ulcerative colitis (severe).

Drug Interactions: MAO inhibitors, Alcohol or CNS depressants, especially anesthetics, barbiturates, and narcotics.

ADVERSE REACTIONS: Prolongs the response to nervous stimulation, potentiates the response to norepinephrine, and inhibits the response to tyramine.

Slight to moderate drowsiness occurs relatively infrequently with Chlorpheniramine Maleate. Other possible side effects common in antihistamines in general include perspiration, chills, dryness of mouth, nose and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

DOSAGE AND ADMINISTRATION: Dosage should be individualized according to the needs and response of the patient. Adults: one capsule every 8 to 12 hours not to exceed 3 capsules daily. Not for use in children under 12 years of age.

OVERDOSAGE: Treatment of the signs and symptoms of overdosage is symptomatic and supportive. In the event of overdosage, emergency treatment should be started immediately.

Treatment: The patient should be induced to vomit, even if emesis has occurred spontaneously. Vomiting by the administration of ipecac syrup is a preferred method. However, vomiting should not be induced in patients with impaired consciousness. Stimulants (analeptic agents) should not be used. Vasopressors may be used to treat hypotension. Short-acting barbiturates, diazepam or paraldehyde may be administered to control seizures. Hyperpyrexia, especially in children, may require treatment with tepid water sponge baths or a hypothermic blanket. Apnea is treated with ventilatory support.

HOW SUPPLIED: Green and clear capsules with green and white beads. Bottles of 100 tablets. NDC 0524-0031-01

Store at controlled room temperature 15-30°C (59°-86°F).

CAUTION: Federal law prohibits dispensing without prescription.

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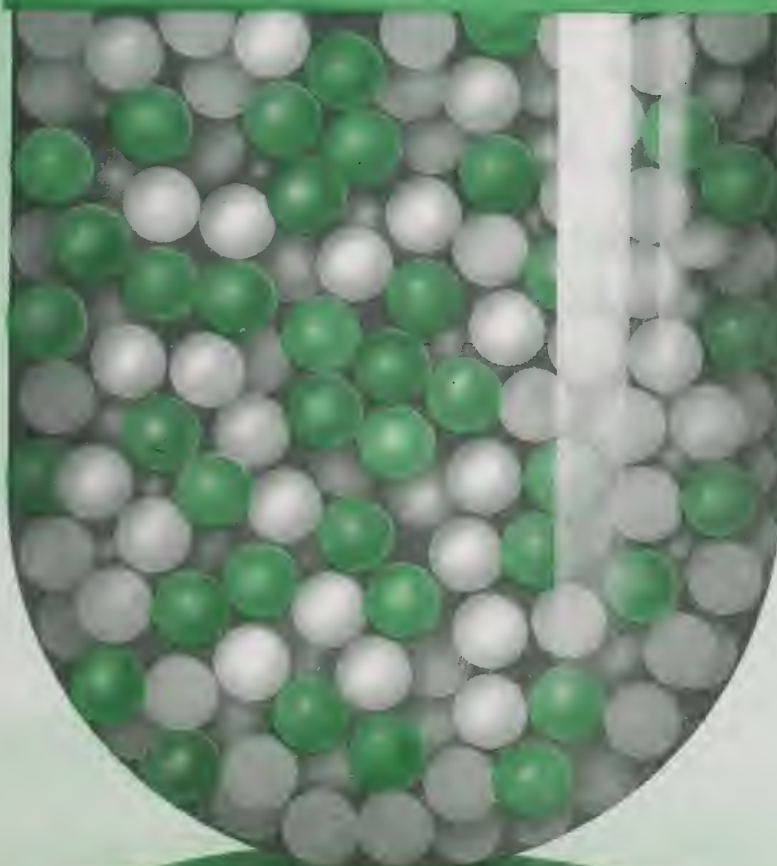
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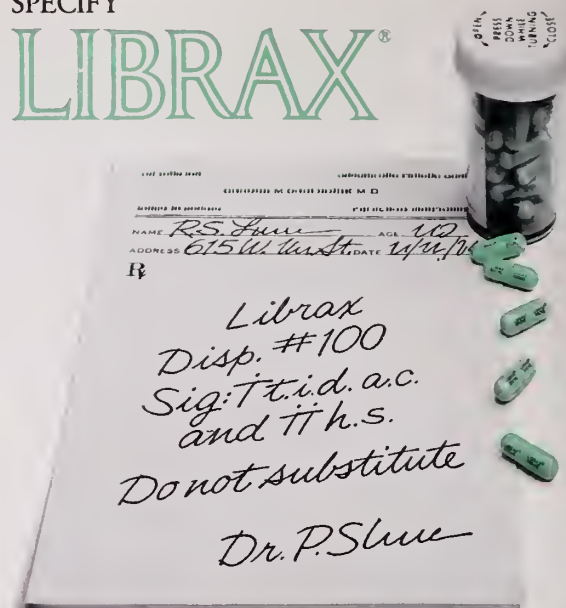
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SPECIFY

LIBRAX®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) Roche to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

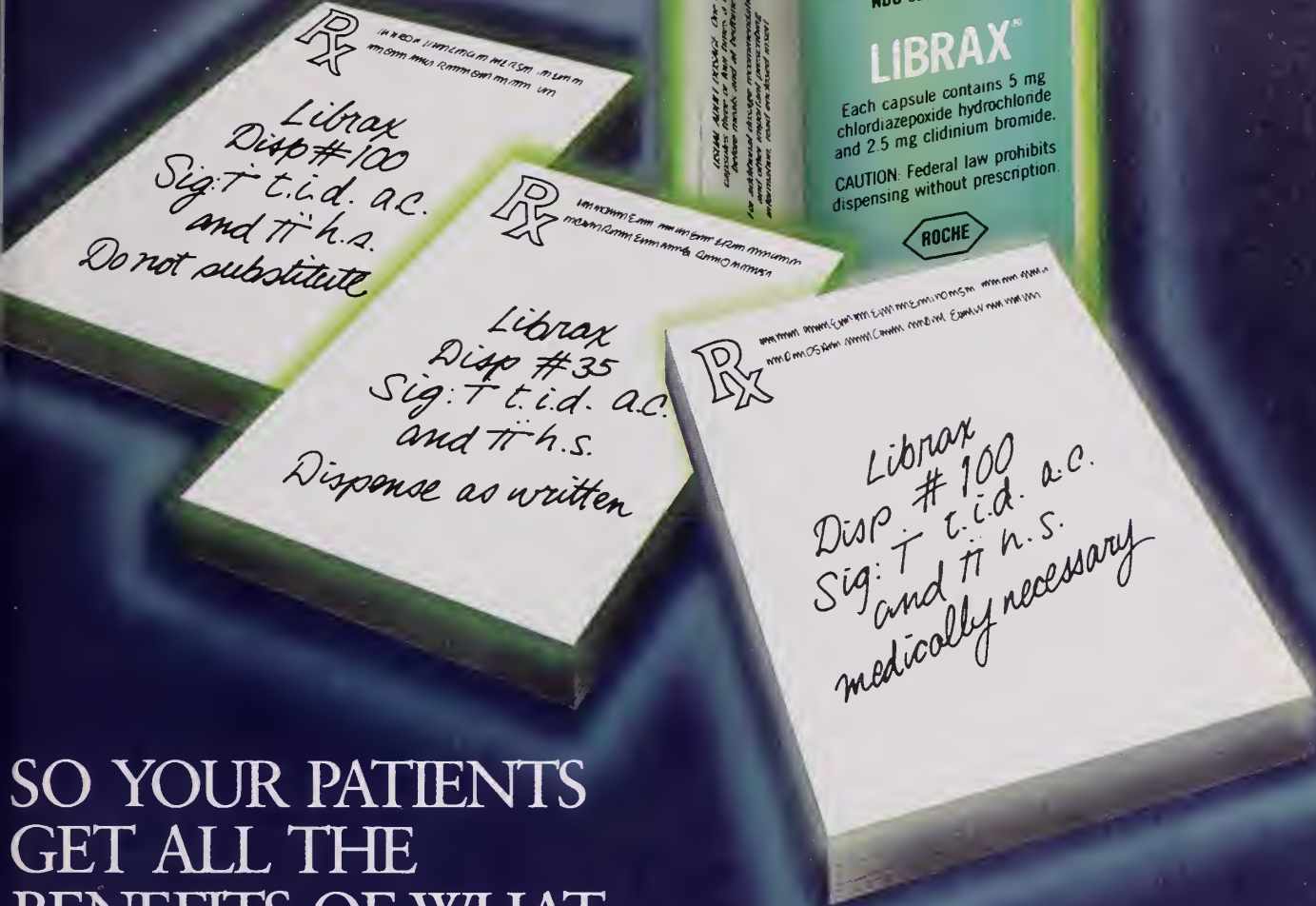
Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur. **Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



LIBRAX®
TO BE SURE...
SPECIFY THE BRAND
CLEARLY



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THEIR PEPTIC ULCER OR
IRRITABLE BOWEL SYNDROME

Although generic pharmaceuticals may have active ingredients like those of the brand-name product, generics may use different manufacturing methods.

By specifying Librax when you write prescriptions for your patients with irritable bowel syndrome and duodenal ulcer,* you can be sure that each dose will provide the needed effect. Librax provides the antianxiety actions of Librium® (chlordiazepoxide HCl/Roche), which has a proven record of safety and efficacy. And working with the antianxiety effect of Librium are the antisecretory and antispasmodic actions of Quarzan® (clidinium bromide/Roche). Thus, when you prescribe Librax, your patients are also assured of specific medication against hypersecretion and hypermotility.

*Librax has been evaluated as possibly effective adjunctive therapy in the treatment of irritable bowel syndrome and duodenal ulcer. Please see summary of prescribing information on the preceding page.

SPECIFY ADJUNCTIVE

LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium bromide.



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In Search of Leaders

Honesty and integrity go hand in hand, and in medicine instilling these qualities in its professionals is imperative. Currently the teaching and learning process in America is being examined. Consider the following:

- One of the great clinicians and fertile minds of our age, Owen Wangenstein, MD, in the twilight of his career, remarked that medicine had long drawn on small town and rural families because of their dedication to the work ethic and capability for original thought.

- The June 3 issue of the *Journal of the American Medical Association (JAMA)* presented the history of John R. Darsee, MD, and his fabricated research at Harvard. Suggestion surfaced that he had earlier employed similar dishonest tactics at Emory University.

- The basic concept and fact remain that due to excellence in American medicine and research, the average life span in the United States of America in this century has risen from 45 years to 73 years.

While grammar school, high school, and college education are being questioned, I think we might look at medical school curricula as well.

An excellent Oklahoma physician recently remarked to me that he had quit teaching because he faced more tape recorders than students when he lectured in the medical school. Thirty years of teaching medical students had convinced him of one thing — there is no substitute for direct interaction between teacher and student in this most important dialogue.

Horace Walpole, in a chatty letter to his friend Horace Mann, suggested and did indeed coin a new word in our vocabulary — *serendipity*. Dictionaries say it is "the happy faculty or luck of finding unforeseen evidence of one's ideas or, with surprise, coming upon new objects or realities which were not being sought."

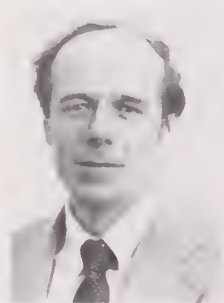
It is often assumed that scientific advances are totally fortuitous. Nevertheless, listening to a tape recorder in a nonmedical setting will not teach the student the awareness needed in the sick room or research laboratory to critically analyze a medical problem and arrive at a logical, humane, and professional judgmental diagnosis.

— Ed L. Calhoon, MD

A Legislative Crisis

Surely everyone likes to think that his own crisis is somehow larger or more meaningful than that of his neighbors or predecessors. The legislative crisis that developed in Washington in late October which dealt not only with physicians' fee reimbursement freeze under Medicare, but also the question of linking mandatory Medicare assignments to hospital staff admitting privileges, did seem objectively to have a certain quality of importance about it. The results of the vote on the floor of the House and possible vote in the US Senate will, of course, be well known before you read this particular page. I cannot, therefore, bring you any fresh news. However, I would like to share with you some color commentary.

Oklahoma was being pelted with flooding rains when the news of the Medicare assignment problem reached the OSMA office by phone late on the afternoon of October 19. Within 24 hours, telegrams stating our position were on their way, not only to all members of the Oklahoma Congressional Delegation, but to all members of the OSMA Board, all OSMA Delegates to the AMA, and all OSMA Council Chairmen. Several telephone consultations occurred between the OSMA officials and the AMA, as well as with our own lobbyist in Washington, John Montgomery. Within



another 24 hours, letters were composed and mailed to the nearly 4,000 members of the OSMA, and similar action correlated with the Tulsa County Medical Society.

The next two days were a weekend, and when Mr. Bickham and I arrived in Washington on Monday, the purpose of our visit was well known in each congressman's office. The response by so many Oklahoma physicians was clearly heard in Washington in a very few days after the absurd concept of linking staff admitting privileges to Medicare assignment was first broached in the halls of Congress. My sincere and personal thanks to each of you who sent a telegram or a letter, or made a call. We all should appreciate the long hours and able work of David Bickham and our OSMA staff.

A second area of activity for which we should all be grateful was exemplified by the very effective work of John Montgomery in this difficult legislative crisis. Not only did John handle the considerable logistical problems from the Washington scene, but his obvious knowledge of the intricacies of the legislative process was most useful. The credibility that John has built with the staff of our delegation in Washington cannot be quickly or easily acquired, and the respect with which John is regarded by our legislators and the AMA staff in Washington bodes well for Oklahoma medicine.

Other legislative crises will certainly be coming. As we enter an election year, it is an exciting time to be involved.

George H. Kamp, M.D.

Optic Nerve Hypoplasia and Visual Function (A Quantitative Correlation)

THOMAS E. ACERS, MD

For more than a century, optic nerve hypoplasia was described as a rare and isolated anomaly, characterized by a small, pale optic nerve and blindness. This study will indicate that this anomaly is not rare; it is often associated with other neural-ocular-endocrine abnormalities and the visual function is quite variable.

For more than a century (1864-1970) optic nerve hypoplasia was described as a rare and isolated ocular anomaly characterized by a small, pale optic nerve and blindness.

Only in the past decade has the varied expression of this abnormality been emphasized and the entire spectrum of the septo-optic-pituitary dysplasia syndrome recognized.

With the advent of ultrasonography and computed tomography, the *in vivo* study of the

optic nerve has been enhanced. The actual size of the optic nerve can be determined and a quantitative correlation between size and visual function established.

This report will present data on the correlation of size of the optic nerve and visual function in 24 patients with optic nerve hypoplasia.

Materials and Methods

Forty-five patients with the diagnosis of optic nerve hypoplasia were identified for study. Twenty-four of these patients were of sufficient age to provide accurate and consistent response to visual acuity testing and 17 patients had quantitative perimetry performed.

Optic nerve diameter measurements were made with the Bronson A-scan in both the horizontal and vertical planes. The echographic area of the optic nerve was then calculated from the formula for determining the area of an ellipsoid, $\pi a \cdot b$, where a equals one-half the horizontal diameter, and b equals one-half the vertical diameter. These echographic area calculations were then compared

Totally supported through an unrestricted grant from Research to Prevent Blindness, New York City, NY

Optic nerve hypoplasia

with normal control figures (matched by general age groups) and expressed as a decimal ratio of normal.

The standard Snellen visual acuity testing was performed on all patients and Goldmann perimetry studies were performed on 17 patients. Stereoscopic photographs of the optic nerves were also obtained.

Results

The normal control optic nerve area measurements ranged from 7.25 square mm to 10.92 square mm with a mean normal area of 9.02 square mm. The control optic nerve diameter measurements were horizontally $3.36 \pm .33$ (two standard deviations) and vertically $3.42 \pm .35$ (two standard deviations). The lowest diametric figure less the standard deviation was used for calculation of the area for comparison with the study group.

The echographic areas of the 24 patients in the optic nerve hypoplasia group ranged from 2.84 square mm (decimal of normal .39) to 6.74

square mm (decimal of normal .93) with a mean echographic area of 4.61 square mm (decimal of normal .63).

Nine of the 24 patients demonstrated "segmental" hypoplasia or the tilted nerve anomaly and formed an overlapping subgroup of echographic area measurements. They usually demonstrated a greater optic nerve area than the general group of optic nerve hypoplasia patients, but still significantly less than the control group area. This group ranged from 4.41 square mm area (decimal of normal .61) to 6.74 square mm (decimal of normal .93) with a mean area of 5.4 square mm (decimal of normal .75). The echographic diameter of these nerves always measured less in the direction of the tilt.

Four of the 24 patients demonstrated unilateral optic nerve hypoplasia.

Visual acuity in the eyes with optic nerve hypoplasia ranged from 20/20 to no light perception. Three of the 24 patients had no light perception bilaterally. Three patients with unilateral hypoplasia had 20/20 in the normal eye and no light perception in the involved eye. One unilateral patient had 20/400 vision in the

Table 1. — Clinical Data

Patient	Age	Sex	Laterality		Vision		Visual Fields
			OD	OS	OD	OS	
1	19	M	x	x	20/40	20/40	lo bitemp
2	8	F	x		NLP	20/20	
3	4	M	x	x	NLP	NLP	
4	8	F	x	x	20/100	gen const	
5	33	M	x	x	20/400	20/40	up bitemp
6	34	F	x	x	20/50	20/40	bitemp
7	15	M	x	x	20/80	20/200	up bitemp
8	22	M	x	x	20/30	20/30	gen const
9	22	M	x	x	20/40	20/20	infer alt
10	5	F	x	x	NLP	NLP	
11	8	F	x	x	NLP	NLP	
12	14	F	x	x	20/400	20/20	up alt
13	5	M	x	x	20/70	20/40	
14	22	F	x	x	20/30	20/400	infer nasal OU
15	13	F	x	x	20/30	20/100	gen const
16	40	F	x	x	20/40	20/40	lo bitemp
17	23	M	x	x	20/200	20/200	gen const
18	5	F		x	20/20	NLP	
19	6	F		x	20/400	20/40	
20	59	M		x	20/20	NLP	central defect
21	57	F	x	x	20/40	20/400	bitemp
22	6	M	x	x	HM	20/400	bitemp
23	26	M	x	x	20/200	20/200	gen const
24	9	F	x	x	20/80	20/200	gen const

eye with a normal size optic nerve but with retinal trauma and 20/40 in the involved eye with hypoplasia.

Furthermore, there appears to be little direct mutual correlation between the size of the optic nerve (echographic area) and its visual function. Patient 23 has an echographic area of

**It is now obvious that
optic nerve hypoplasia often
does not represent just
an isolated ocular anomaly.**

.90 normal in one eye and .79 in the other eye, with a visual acuity in each eye of 20/200. Patient 8 has an echographic area of .79 normal in both eyes with a visual acuity of 20/30 in each eye. Also, patient 11 has the same echographic area of .79 and no light perception in both eyes (Table 1).

Figure 1 is a simple scattergram showing the lack of direct mutual correlation between optic nerve size and visual acuity for 44 eyes with optic nerve hypoplasia. There is an increased density at both ends of the scatter with a general tendency for the larger optic nerves to have the better visual acuity. Most of the tilted nerves are represented in this latter density group (Fig 1).

Visual field studies were performed on 17 patients and demonstrated bitemporal defects in seven, generalized constriction in six, altitudinal defects in two, binasal defects in one, and central defects in one.

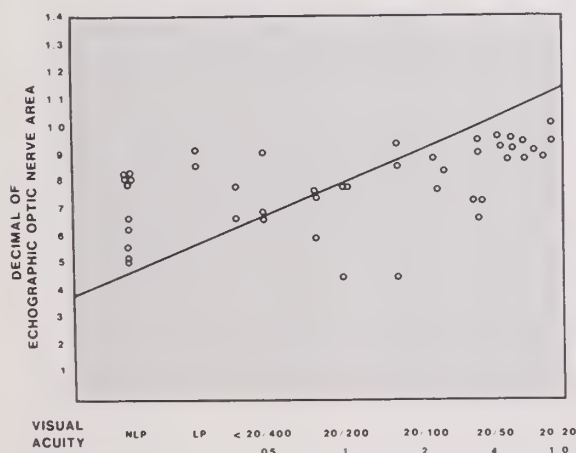


Figure 1.

Six of the 24 patients demonstrated the tilt-conus-ectasia syndrome and three others the horizontal tilted disc anomaly. One patient with a vertical tilt and one with a horizontal tilt were unilaterally affected and both eyes were deeply amblyopic. Five of the seven bilateral cases had visual acuity of 20/20 to 20/40 and two were in the 20/100 to 20/200 range.

The field defects in this subgroup of patients with tilted nerves invariably corresponded to the direction of the tilt. Patients with the inferior tilt-conus-ectasia syndrome demonstrated upper and predominantly temporal field defects which often extended slightly into the upper nasal quadrant. One patient with a superior tilt demonstrated lower altitudinal field defects. One patient with bilateral nasal tilt of the nerves demonstrated lower bi-temporal field defects. One patient with bilateral temporal tilt of the nerves and -22.00 diopters of myopia demonstrated binasal field defects.

Tables 1 and 2 present the pertinent clinical and echographic data regarding these 24 patients with optic nerve hypoplasia.

Discussion

Since the earliest descriptions of optic nerve hypoplasia in the mid-nineteenth century, it has been assumed that this is a rare ocular anomaly often associated with blindness.¹

From 1864 to 1966, 22 cases of optic nerve hypoplasia had been reported in the world literature.² In 1970 alone, 45 additional cases were reported in two published series by Edwards and Layden³ and Walton and Robb.⁴ Since then over 400 cases have been either reported or alluded to in the literature.⁵ Optic nerve hypoplasia is obviously not as rare as it was previously presumed to be.

The association of optic nerve hypoplasia with structural midline brain defects was described in 1956⁶ and the association of these defects with hypopituitary function in 1970.^{7,8} Several reports of these associated ocular neuro-endocrine defects have appeared during the past several years.^{9,12} More recently the concomitant associated with optic nerve hypoplasia and the craniofacial dysraphic states has been described.¹³ It is now obvious that optic nerve hypoplasia often does not represent just an isolated ocular anomaly.

The general consensus that optic nerve

Optic nerve hypoplasia

hypoplasia is almost always associated with blindness has been historically perpetuated and only recently has it been seriously questioned. It is of interest to note though that in 1915, Schwartz¹⁴ described a patient with bilateral optic nerve hypoplasia, 20/40 visual acuity, and binasal field defects. In 1972, Seely and Smith¹⁵ reviewed 12 cases and added 4 of their own and emphasized the wide variation in visual acuity and visual fields in this group of patients. Other more recent studies have further verified these findings and emphasized the wide spectrum of visual function in optic nerve hypoplasia.^{16,17}

This study confirms these more recent reports, utilizing echographic area measurements of the optic nerve to quantitatively document and correlate optic nerve size with visual function.

Summary

Twenty-four patients with various forms of optic nerve hypoplasia and in the literate age

group were studied to provide data on the correlation of optic nerve size and visual function.

Echographic area measurements of the optic nerves were calculated and visual acuity was tested on all patients. Perimetric studies were obtained in 17 patients.

The size of the optic nerves varied from 39% to 93% of normal, as compared to the control group.

Visual acuity ranged from 20/20 to no light perception, without close mutual correlation between the size of the optic nerve and its visual function. In general, the larger optic nerves did have the best correlated visual acuity, but with significant variation throughout the scatter comparison.

Visual field studies demonstrated a variety of field defects: bi-hemianopic, central, altitudinal, and generalized constriction.

Optic nerve hypoplasia is not a rare and isolated ocular anomaly. It does have a wide spectrum of clinical expression as it relates to visual function. It may also be associated with structural midline brain defects, hypopituitarism, and craniofacial abnormalities. □

Table 2. — Ultrasonography

Patient	Diameter (mm)		Area		Dec of Normal	
	OD	OS	OD	OS	OD	OS
1	2.70 x 2.70	2.70 x 2.70	5.72	5.72	.79	.79
2	2.70 x 2.70	3.00 x 3.10	5.72	7.32	.79	1.00
3	1.55 x 2.33	1.55 x 2.33	2.84	2.84	.39	.39
4	3.00 x 2.30	3.00 x 2.30	5.42	5.42	.75	.75
5	2.80 x 2.80	2.80 x 2.80	6.15	6.15	.85	.85
6	2.80 x 3.00	2.80 x 3.00	6.59	6.59	.91	.91
7	2.71 x 2.31	2.71 x 2.71	4.91	5.76	.68	.79
8	2.71 x 2.71	2.71 x 2.71	5.76	5.76	.79	.79
9	2.77 x 2.70	3.10 x 2.77	5.87	6.74	.80	.93
10	2.33 x 2.33	2.06 x 2.06	5.67	3.33	.78	.46
11	2.70 x 2.70	2.70 x 2.70	5.72	5.72	.79	.79
12	3.02 x 2.02	3.02 x 2.02	4.79	4.79	.66	.66
13	2.42 x 2.32	2.42 x 2.32	4.41	4.41	.61	.61
14	2.70 x 2.70	2.70 x 2.70	5.72	5.72	.79	.79
15	2.38 x 2.71	2.33 x 2.33	5.06	4.26	.70	.59
16	2.30 x 2.70	2.30 x 2.70	4.87	4.87	.67	.67
17	3.10 x 2.70	2.70 x 2.70	6.57	5.72	.91	.79
18	3.00 x 3.20	2.33 x 2.33	7.53	4.26	1.00	.59
19	3.08 x 3.08	2.71 x 2.33	7.44	4.96	1.00	.68
20	2.99 x 3.10	2.67 x 3.05	7.15	6.40	1.00	.88
21	2.80 x 3.00	2.60 x 3.00	6.59	6.12	.91	.84
22	2.80 x 2.90	2.71 x 2.71	6.60	5.76	.91	.79
23	3.10 x 2.70	2.70 x 2.70	6.57	5.92	.90	.79
24	2.80 x 3.10	2.80 x 3.10	6.81	6.81	.83	.83

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A One-Year Follow-Up Study of the Damon Group Hypnosis Smoking Cessation Program

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**Hypnosis, as a method to quit smoking,
is reviewed. Of 783 smokers who
participated in a large group smoking
cessation program, 14% remained
abstinent a year later.**

The adverse health consequences of smoking have become more evident since the first Surgeon General's report on Smoking and Health was published in 1964. Subsequently, a number of techniques have been developed to aid smokers in their attempts to quit. Hypnosis, as one of the methods, has been used for some time. Different forms of hypnotherapy have been used with a range of success reported. Owens and Samaras (1981) reported a

"quit" rate of 28% six to nine months after a single large group hypnosis session. Grosz (1978) reported a total abstinence from cigarette smoking among 44% of his subjects three months after a single individual hypnotherapy session. Sanders (1977) studied a small group of smokers who were involved in "mutual group hypnosis" during which time hypnotized subjects gave suggestions to another hypnotized subject. After ten months, 68% had abstained from smoking cigarettes. Additional reports (Johnston and Donoghue, 1971; Percy and Mullen, 1975; Spiegel, 1970; Stanton, 1978; Watkins, 1976) indicate various alterations in the protocol of hypnosis in smoking cessation areas with marked variation in follow-up and reported success.

There exist among these studies some problems with comparability. The following significant data are not uniformly presented:

- the percent of subjects not completing the program and measures of their behavior;

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- the percent of subjects not reached for follow-up data. Often if reported they are excluded where determination of success rates is made;
- the length of time of follow-up (varies from three months to one year).

This type of absence or variability in the above data can grossly bias the results in a favorable direction. Such neglect is not specific to studies on hypnosis as a method of smoking cessation, but is characteristic of most reported studies in smoking cessation. Schwartz (1969) attempted to recalculate the results of 100 smoking cessation programs reported from 1957 to 1968 by standardizing the above points and was thwarted due to poor record keeping and extreme variation in reporting by the individual investigators.

In attempts to standardize evaluation designs and reporting of results, the major recommendation from the Second World Conference on Smoking and Health in 1971 was that governments and voluntary health agencies undertake the responsibility for evaluating major smoking withdrawal programs. Following issuance of that report, the National Inter-agency Council on Smoking and Health (1974) developed guidelines for research on evaluating smoking cessation programs. The following report of an evaluation of a large group hypnosis smoking cessation program attempted to follow the recommendations of the above agencies.

Method

Treatment. A total of 783 smokers participated in a single group hypnosis session sponsored by a voluntary health agency. Participants had been recruited via public service announcements in the local media and were charged a \$25 fee for the session.

An experienced clinical hypnotherapist conducted four separate group sessions in which

190 to 200 individuals participated. This therapist had spent several years helping people to stop smoking through large group hypnosis sessions.

For the first seventy minutes of the ninety-minute session the therapist described the principles of hypnosis, shaped expectancies, and answered questions. Hypnotic induction and suggestions were administered in the remaining twenty minutes. Suggestions by the therapist focused on desensitizing participants to cravings to smoke and to environmental cues. For example, the therapist suggested that "other people's smoke will not bother you and cause you to want a cigarette." Cassette tapes were available at an additional cost and could have been used by participants for post-treatment reinforcement.

Instruments and Data Collection. Prior to the group session, participants completed questionnaires on their socio-demographic characteristics, smoking status and history, social support, smoking habits of significant others, health status and beliefs, and health locus of control (HLC).

At one year post-treatment, a follow-up questionnaire and postage-paid return envelope were mailed to each participant. Information on smoking habits, social support, coping mechanisms subsequent to intervention, current health status, beliefs, and HLC was requested. Nonrespondents were mailed a second questionnaire one month later. Two weeks after the second mailing nonrespondents were contacted by phone, and an inquiry was made as to their current cigarette smoking status. Phone calls were conducted by volunteers who donated their time to the voluntary health agency overseeing the program evaluation. These volunteers were given a script and were trained to get the desired information. Numerous attempts were made at a variety of different times and on different days of the week. Information was accepted only from the participants in the study, and they were all encouraged to complete and return the questionnaires that they received. In addition, a postcard reminder was mailed out one week after phone contact to encourage return of the post-treatment questionnaire.

Results

This study includes data from the one-year post-treatment follow-up. Data from the matched pre- and one-year post-treatment

Table 1. — Questionnaires Returned by Multiple Follow-Up Procedures, One Year after Cessation Program

Method	Questionnaires Returned	% of Total (N = 783)
1st mailing	188	24
2nd mailing	109	14
Phone calls	54	7
Postcard	21	3
	372	48%

Follow-up study

questionnaires represented 219 participants consisting of 70 males and 149 females whose ages ranged from 15 to 71 ($M = 42.6$, $SD = 12.1$). The data from this sample is presently being analyzed.

Response Rate. Results of the multiple methods used to increase the response rate for the questionnaires are depicted in Table 1. Of the 372 questionnaires returned, 188 (51%) were returned initially and 184 (49%) were returned after subsequent contact with the participants. The total of 372 yielded a response rate of 48% (Table 1).

An additional 246 participants responded to the phone survey only, a response rate for these of 31% (Table 2). All attempts to gather information about the participants' current cigarette smoking status yielded responses from 618 subjects or 79% of the original 783 participants.

Success of Quitting. Of the 618 participants who responded to either the questionnaire or phone survey, 113 reported not smoking at all since treatment. This represents a quit rate of 18% if one does not include the 165 nonrespondents. However, when including the nonrespondents, the quit rate drops to 14%. An additional 19 participants reported that they smoked regularly after the treatment but have since become ex-smokers. This represents 2% of the population. Of those currently smoking,

25 (3%) reported that they smoked occasionally since treatment and 461 (59%) reported that they are presently regular smokers. Table 2 reviews the data relative to the method of response. The telephone survey respondents were significantly less likely to be abstinent at the follow-up than the questionnaire respondents $\chi^2 (1) = 24.09$, $p < .001$ (Table 2).

Discussion

This study attempted to evaluate the success of a cigarette smoking cessation program that incorporated principles of hypnosis in a large group setting. The standard for success was abstinence from cigarette smoking for the period of one year post-treatment. Nonrespondents to the one-year follow-up were included in determining the percent of abstinence. In terms of complete cigarette smoking abstinence, this study yielded a 14% success rate. This compares to the 13% one-year abstinence reported by the Vermont Lung Association (1981) for a similar large group hypnosis smoking cessation program. Owens and Samaras (1981) report a "quit" rate of 27.53% six to nine months after a similar single large group session. Their success rate is based upon the number of participants who responded to their attempts to collect data and not upon the number of participants in the program. Such failure to include nonrespondents in determining success rates, as well as failure to report the non-response rate, carries a grave danger of biasing the results.

This study demonstrates what additional re-

Table 2. — Reported Smoking Behavior of Participants of a Group Hypnosis Cessation Program One Year Later by Questionnaire and Telephone Survey

	Questionnaire	Phone Survey	Total Response (N = 783)	% of Total
Ex-smoker since treatment	89	24	113	14
Smoked regularly, but now ex-smoker	15	4	19	2
Smoked occasionally since treatment	17	8	25	3
Regular Smoker	<u>251</u>	<u>210</u>	<u>461</u>	<u>59</u>
	372	246	618	78*
Nonrespondents = 165 (21%)				
* actually 79%; difference due to rounding error of the categories				

searchers (Berglund, 1969; Wagner, Note 1) have shown. Data from persons responding promptly to a mail questionnaire contain a disproportionate number of ex-smokers, while those who are contacted after repeated follow-up attempts are almost all smokers. The necessity of aggressive follow-up attempts is explicit to reduce the margin of error associated with small response rates. It is imperative that valid quit rates include nonrespondents as failures.

Limitations and Conclusions. The self-report methodology of this study is its major limitation. While self-reports of smoking habits tend to be reliable (Colletti, Suprick, Abueg, 1982), the retrospective nature of follow-up in particular could introduce bias due to loss of recall over time or to the influence of degree of success on reporting past events.

This study sought to determine the success of a large group hypnosis smoking cessation program. Of the 783 subjects who participated in the program, 113 have not smoked at all since the program. The follow-up period was one year. Aggressive data collection methods yielded a response rate of 79%. □

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V: Management of Meconium Staining in the Delivery Room

ROGER E. SHELDON, MD

A simple suctioning technique, carried out before the delivery of the infant's shoulders, can greatly reduce the incidence of meconium aspiration.

This outline reviews the obstetrical and pediatric management of meconium staining of the amniotic fluid at the time of delivery. Meconium staining occurs in 10% to 15% of deliveries. With the usual management of the fifties and sixties, about 10% of these, or 1% of all infants, aspirated meconium and developed aspiration pneumonia as a result. In the seventies a method was found which makes it possible to reduce this incidence to about one per thousand. The method is simply the suctioning of the infant's airway with a catheter *before* the delivery of the infant's shoulders.¹ This outline details the approach and the pediatric suctioning that should follow.

I. Obstetrical Management

A. Be Prepared.

1. Be alert for meconium staining — it is always a sign of fetal difficulty (even with a breech presentation) until proven otherwise. It is also an indication for close fetal monitoring — either electronically or by full-time observation of the mother and fetus by trained personnel.
2. Assemble the proper equipment.
 - a. Equipment for resuscitation.
 - b. DeLee suction trap or suction catheter attached to wall suction.

B. Proceed with the delivery.

1. Deliver vaginally or by cesarean, as indicated. (The catheter suction method to be described will not be as effective during cesarean delivery, but this fact should not change the indications for cesarean.)
2. When the infant's head has been delivered, have the mother stop pushing.

C. SUCTION THE INFANT'S MOUTH AND NOSE TO THE LEVEL OF THE VOCAL CORDS USING A CATHETER.

1. A suction bulb will not reach far enough to do the job.
2. This is the essential step.
3. It works presumably by removing the maximum amount of meconium while the chest is compressed in the birth canal. This would also explain why the method works less well with cesarean section. After such suction, the infant's first breathing efforts draw air, not meconium, into the lungs.

D. Complete the delivery.

E. Begin the pediatric steps below.

II. Pediatric Management

A. Observe the usual precautions in managing an asphyxiated infant. See previous articles^{2,3} in this series for details.

1. Keep the infant warm.
2. Proceed quickly with all steps.

B. Minimize stimulation and handling of the infant to reduce the likelihood that he/she will breathe before the following steps can be carried out. There is no proven safe and effective method for stopping the infant's breathing if it begins spontaneously.

C. Inspect the hypopharynx and larynx by direct laryngoscopy, looking for the presence of meconium.

D. Intubate the trachea and suction it before the infant takes his/her first breath. Many operators will intubate for suction only if meconium is seen at or through the cords. A few infants will have meconium in the trachea without visible meconium in the throat, so intubation for every meconium-stained baby is recommended.

1. Intubate as usual. (For details see the preceding article in this series.²)
2. Without removing your surgical mask,

suction the tube with your mouth and at the same time extubate. This will extract meconium both with and through the tube.

3. Reintubate the infant with a clean tube and ventilate with oxygen. Some operators will suction a second or third time if the infant is in good condition and no difficulties are encountered.
4. Omit this intubation if the infant is crying and breathing deeply — the meconium is already aspirated and you stand a greater chance of injuring an infant who is struggling.

By this combination of "prenatal" and postnatal suctioning, aspiration of significant amounts of meconium can be prevented in most infants. One of the most devastating neonatal illnesses can thus be avoided in most vaginally delivered, vertex presentation infants.

I hope that these outlines have provided assistance in your management of sick and imperiled infants. I extend an invitation to any qualified physician to arrange a tailor-made "miniresidency" at the NICU at Oklahoma Children's Memorial Hospital. These can range from one to ten days in length and can be arranged by talking with me or any of the OU neonatologists at (405) 271-5215. □

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A History of Clinical Thermometry

RALPH L. McLAURY, MD

Thermometers have been used in clinical medicine for more than three hundred years. What did the first ones look like and how was their shape of today established?

For thousands of years fever has been recognized as a cardinal indicator of illness in humans. In ancient medicine, fever was an ill-defined concept of an increase in temperature as compared to the temperature found in health. How did those ancient physicians determine that fever was present? By what clinical criteria was the impression of fever obtained?

As Hippocrates observed, "And with regard to the sick, is it not those who experience a rigor that the most acute fever is apt to break out?"¹ Yet how did he decide whether or not the patient had fever? We may use as a guide his discussion of apparently febrile patients. His descriptions are quite lucid: he clearly had seen acute onsets with chilling, delirium, and the sweats terminating fever. A curious obser-

vation of his was that fever leaves the body from the feet.

Nevertheless, aside from the dramatic episodes, with the readily observable signs, how could Hippocrates know of an elevation of body temperatures from normal or, for that matter, did he have a concept of a "normal" body temperature? He stated, "Growing things have the most innate heat." Heat was defined by him as a mixture of cold and fire presented as a balance of the two in a normal person. Fever was an excess of heat or a deficiency of cold. His method of taking temperature is not known to us, and clinicians can only surmise that he took a reading of the patient's temperature with his hands. This method is known today primarily for its inaccuracy, but is still in common lay use.

Hippocrates did discern that "older people" do not usually have fever as high as younger people: "In old persons the heat is feeble, and therefore they require little fuel, as it were, to the flame, for it would be extinguished by much. On this account fevers in old persons are not equally acute, because their bodies are cold."² In summary, although a concept of

temperature was taught by him, he had no objective way that we know of to measure the temperature.

The first physician to devise a scale for measuring the qualities of heat and cold in the body was Galen. This Roman clinician, who practiced in the first century AD, developed a theory of disease causation based upon the ideas of Aristotle, a Greek philosopher and scientist. Aristotle said that all matter was made up of four qualities: heat, cold, dryness, and moistness; however, he suggested no method or manner to determine the proportion of these qualities.

Galen felt that health differed from disease in the proportion of these four qualities as found in an individual. A person's "complexion" was determined by the proportions of the qualities, each tempering the effect of the others. The word *temperament* reflects this concept, and the word *temperature* once meant the same thing but has since come to have a precise physical meaning. So, for every person, there was an "equal temperature," with each having his own normal.²

Galen also introduced the concept of a "neutral temperature" which was neither cold nor hot. As the only methods of temperature determination were subjective, and a "hot-tempered" person might perceive another's temperature differently than would a "cold-tempered" person, he suggested that the neutral point for temperature measurement be an equal mixture of ice and boiling water. The temperature of the solution, we know today, would be dependent on the weight of the ice used, and Galen did not specify whether the ice and water were to be mixed according to weight or volume.

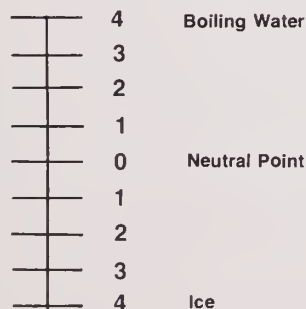


Figure 1. — Galen's scale — a hypothetical construction by the author.

Figure 2. — First published figure of a thermoscope.



As an adjunct to this concept, Galen suggested a scale that had four degrees on either side of a neutral point. Figure 1, is a present-day representation of his concept, with the scale oriented vertically to correspond with the orientation of a room thermometer. One end of the scale represents the temperature of boiling water, and the other end that of ice. The neutral point would be the temperature of a mixture of the two. Aside from the end-points and the "zero" reading, the other degrees in his scale had no objective qualities, but were to be determined by the interpretation of the physician. In the fourteen hundred years that followed, Galen's scale was refined by succeeding physicians seeking more accurate determination of temperature. No instrument had yet been devised.

One of the refinements of Galen's scale was made by Joannes Haslerus in his *De Logistica Medica* in 1578.² This medical treatise is primarily concerned with the correct compounding of medications, which depend on finding the normal temperature of the patient. Haslerus furnished a chart by which this temperature could be determined. The temperature of any individual depended not only on his or her particular mixture of qualities, but also on the current latitude, an inhabitant of 45° N being at the zero point on Galen's scale, and an inhabitant of 70° N being at the second degree of cold.

Haslerus's scale ran vertically from the fourth degree of heat at the bottom to the

fourth degree of cold at the top, presumably oriented to the degrees of latitude from 0° to 90°, and representing a reversal of the scales to which we are accustomed. This scale, with its many graduations, demonstrates that ideas about temperature and temperature determination were no novelty for the times. Physicians' minds were thus prepared for the later development of an instrument to actually measure temperature.

To better discuss the instrument subsequently devised, definitions are in order. A *thermoscope* is an instrument which shows temperature change but does not have a scale. A *thermometer* shows the change in temperature also but has a scale, usually with predetermined end-points, which allows a quantification of temperature change.

Who invented the thermoscope? Who invented the thermometer? It is beyond the scope of this paper to discuss this contentious matter in any detail; however, four men are credited with the invention of these instruments. Galileo Galilei, the distinguished Italian mathematician, has been given credit on the basis of a letter written to him by an admirer, Sagredo. No mention of a thermometer is made in Galileo's writings. The 1975 edition of *Encyclopedia Britannica* also credits Galileo. The second man, Robert Fludd (1574-1651) of St John's College, Oxford, a physician and mystic, claimed to have taken the idea from a fifth century AD manuscript. More discussion on this point will be found later. Cornelius Drebel (1572-1634) a Dutch mechanic and inventor, used the principle of the thermoscope to build a "perpetual motion" apparatus. He also built the first submarine. The last contender, and the one of most interest to us as physicians, is Santorio (also called Sanctorius or Santorre) who was the first to use an air thermometer in patient care.

Santorio Santorio was born at Capidistra, Italy (modern Koper, Yugoslavia) in 1561. He was awarded an MD degree by the University of Padua in 1582. He died in 1636, in Venice. Credited with being the first physician to employ precision instruments in the practice of medicine, Santorio is perhaps best remembered for his studies on basal metabolism, which introduced quantitative experimental procedure into medical practice.³ As far as is known, he was the first to apply a scale to the

thermoscope. His scale had 110 divisions, with the heat of a candle and the cold of snow representing the end-points.

In examining the thermoscope (Figure 2), one may see that the element placed next to the temperature source is glass-enclosed air. The liquid marker for indicating the degrees was "spirit of wine" (alcohol) which was colored for easier visualization. As the air became heated, the level of liquid in the tube would drop, showing the degrees of heat; as the air was cooled, the level of liquid rose, indicating degrees of cold.

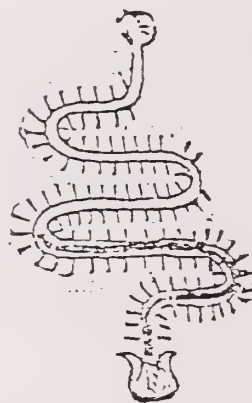


Figure 3. — Clinical thermometer of Santorio, for oral use.

Santorio's instrument had a scale and thus was a thermometer. The scale was read in a fashion that is opposite to the way it would be read in a present-day thermometer, hot being shown by a low liquid level. Note that liquid not in the tube of the thermometer is in a container, serving as the reservoir, that is open to air, thus allowing barometric pressure to affect the temperature reading. Figure 3 shows an oral thermometer and Figure 4 shows the oral thermometer in use.

Figures 5 and 6 show instruments especially designed for their particular use. Figure 5 is a precordial thermometer for taking temperature over the heart. Figure 6 is an illustration of the thermometer used to take the temperature of the breath (the breath was felt to be a direct indicator of the heart's temperature). Another instrument, not shown, was designed to take the temperature of the hand.

An important instrument, with which the thermometers were used, was the *pulsilogium*. This was a development originating from Galileo's pendulum. Note the differing dial

faces in Figure 7 and the pendulum clearly visible under the upper dial. A simple pendulum used as a hand-held version was apparently as satisfactory as the two instruments pictured but would more likely not have been as accurate as they.

What was the purpose of the pulsilogium? A thermometer was placed in the mouth of the patient and the pulse rate was taken through a predetermined number of beats of the pulsilogium. The results were then recorded and, as the readings were taken over several days' time, they were compared with each other and correlated with the clinical improvement or deterioration of the patient's condition. Santorio said it was very difficult to compare the different readings without the use of the pulsilogium.⁴ In effect, this instrument was used as a timepiece, watches with minute hands not having been invented yet. Additionally, the rate of change of the temperature was also recorded.

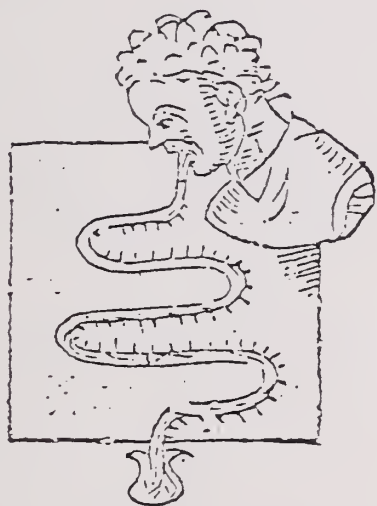


Figure 4. — Clinical thermometer, oral, being used to take temperature.

Santorio corresponded frequently with Galileo, so his use of the pendulum could not be considered unusual but an innovative attempt to quantify temperature taking. He also wrote to Galileo about his thermometer: "I wish to tell you about a marvelous way in which I am accustomed to measure, with a certain glass instrument, the cold and hot temperature of all regions and places, *and of all parts of the body* (italics mine); and, so exactly, that we can measure with the compass the degrees and ultimate limits of heat and cold at any time of the day." And again, he wrote: "For we have an

instrument with which not only the heat and cold of the air is measured, but all the degrees of heat and cold of all parts of the body, as we show to our students at Padua, teaching them its uses; and they have heard about this novelty with no little astonishment."⁵ How he was able to take the temperature of "all parts of the body" must remain a matter for conjecture.

In referring to his thermometer, Santorio related that it was an old instrument, presumably referring to the steam-powered engine invented and refined by Hero(n) of Alexandria, a Greek mathematician (c AD 62). Hero's concept, the forerunner of the jet engine of today, required the application of heat.⁶

It is another Greek invention, the sun-fountain of Philon of Byzantium (c 100 BC), from which the thermometer is more clearly descended. Philon apparently intended to show the effect of heat, not measure temperature.² The apparatus he derived is shown in Figure 8, an illustration taken from Robert Fludd's writings. It was a vessel partially filled with water and vented through a tube of lead; it was sealed except for the opening at the tube end. In the picture, it is the left-hand figure, the one with a bent tube. The sun struck the sealed vessel, A, and the absorbed heat caused the fluid in the tube to descend into the open vessel, B. When the apparatus was placed in the shade the liquid in container B would be drawn up into the tube, I. The figure to the right makes obvious the relationship of Philo's sun-fountain to the thermoscope and to the thermometers of AD 1617. This illustration is an adaptation of the original which Fludd had found in a fifth century AD manuscript.

As the thermometers of Santorio's time were open to the air, they were sensitive to barometric pressure. In 1654, Ferdinand II, Grand Duke of Tuscany and an enthusiastic amateur scientist, not only made thermometers in the usual form of the day by filling the bores with alcohol, but also closed both ends, sealing the fluid within the bulb and stem. These instruments were the first that were insensitive to barometric pressure. His innovation was widely accepted. Now, aside from calibration of the bore, the primary obstacle to the standardization of the thermometer was the development of reproducible end-points and a meaningful scale.

Galen's end-points were ice and boiling water, with the neutral point being a mixture

of these two. Santorio used the heat of a candle and snow. The orientation of Santorio's scales and of the instruments in general use in that period were the reverse of present-day usage. That is, the top of the thermometer's scale showed the coldest temperature and the bottom showed the hottest. Reference points made the thermometer a more useful instrument than the thermoscope. Different end-points for the scales were selected by individuals involved in the subsequent development of the thermometer, with general agreement only on the cold points. Sagredo, Galileo's correspondent, selected snow and salt as the cold end-point and the heat of summer as the other. Newton, the English mathematician, chose compressed melting snow and blood heat ("contact with the human body").⁵ As the utility of reference points became clearer, three scales came into common usage: those of Fahrenheit, Réaumur, and Celsius.

In 1709, Ole Römer, a Danish astronomer who discovered the finite speed of light, wrote that he had used the boiling point of water and melting ice as the end-points of his scale. His work is primarily of interest because it influenced Fahrenheit in his scale selection and the calibration of thermometer tube bores.

Daniel Gabriel Fahrenheit was born in 1686 in Danzig, Germany. He used a mixture of ice and sea-salt as the 0° point of his scale and as the upper point he used body heat, determined by placing the thermometer in the mouth or axilla of a healthy man, which he determined as 96°. He did not use the boiling point of water since the effect of atmospheric pressure had been recognized by this time. His scale came into use by 1740.

Figure 5. — Clinical thermometer, precordial. This was placed over the heart.

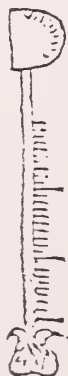


Figure 6. — Clinical thermometer, for taking temperature by means of the breath.
C 1613.

Rene-Antoine Ferchault de Réaumur developed a scale using the melting point of ice, or the freezing point of water, and the boiling point of water. His assigned values were 0° and 80°, 80° being the upper point of the scale. From 1739 through the early twentieth century his scale enjoyed popularity, particularly in France. As late as the 1916 version of its *Excerpta Therapeutica*, the Burroughs Wellcome Company felt it appropriate to include Réaumur's scale in the temperature conversion tables.

The development of the centigrade scale was advanced principally by Anders Celsius. A professor of astronomy at Uppsala, Sweden, from 1730 until his death in 1744, Celsius initially set the 100° mark as the melting point of snow and the 0° mark as the boiling point of water. Linneaus, the famous Swedish botanist and taxonomist, is given credit for reversing the centigrade scale orientation in 1745.

As spirit of wine, the liquid in early thermometers, was replaced by mercury, (with the exception of meteorological instruments, since mercury freezes at -38° centigrade and alcohol at -70° centigrade) thermometers gained standardization, lacking but one refinement to become the instrument in clinical usage today. That refinement was a constriction in the tube between the indicating scale and the reservoir holding the mercury. This constriction makes the instrument into a maximum thermometer — one that will indicate the highest temperature reached by the instrument and hold that reading after the thermometer has been re-

moved from the site of observation. The constriction has taken several forms. The original one separated the column of mercury with a centimeter of air, a so-called "speck of air," and was designed in 1832 by a geologist, John Phillips. The instrument was oriented horizontally. His "speck of air" is difficult to conceptualize in practice and an illustration of his instrument is not available.

The earliest patent for a clinical thermometer utilizing the constriction in the bore of the tube familiar today was granted to Negretti and Zambra in England on March 8, 1852.⁵ Two other instrument manufacturers produced similar instruments, Casella and Harvey & Reynolds, the latter manufacturing a six-inch instrument for clinical use. By 1880, the clinical thermometer had reached the form used today.

With the new standardized and calibrated instrument, it was only a matter of time before its use was explored and exploited in medicine.

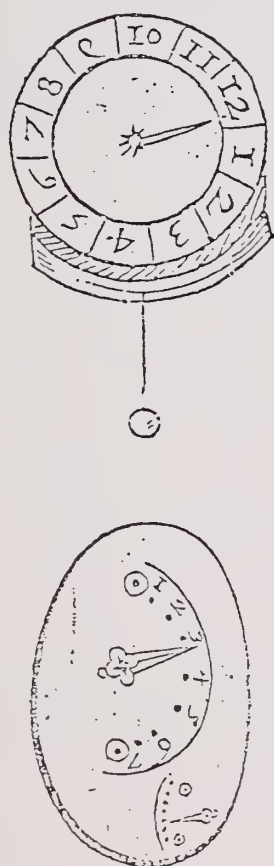


Figure 7. — Two examples of a pulsilogium.
Note the variation in the dial faces.

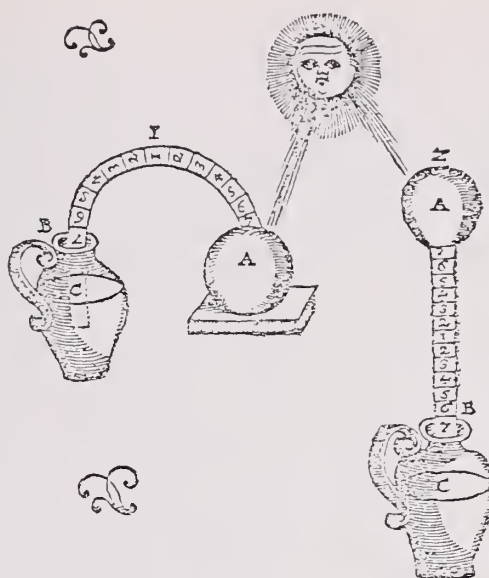


Figure 8. — The sun fountain of Philo of Byzantium. C 100 BC.

One of the earliest treatises on thermometry in clinical usage was by C. A. Wunderlich, physician and professor at the Klinik of the University of Leipzig. Entitled *On the Temperature in Disease: A Manual of Medical Thermometry*, it was published in 1868. In it Wunderlich gives an account of the history, instruments, and historical methods of clinical thermometry, with an annotated bibliography on the subject. He modestly informs us that he had taken temperature observations in 25,000 cases, and "millions" of single observations before publishing his book. His goal was to determine whether diseases in their progress followed fixed rules and whether this progress could be displayed by the course of the temperature. A partial listing of a few of his chapters will convey the thoroughness of his work: "Value of the Thermometer in Medical Practice," "The Art of Medical Thermometry," "On the Thermometer in Health," "Causes of Altered Temperature in Disease," and "The Diagnostic Value of Single Observations." His studies represented a milestone on the use of the thermometer as a clinical instrument.

Worthy of note, also, are his stated qualifications of a medical thermometrist: "Any trustworthy, honest, and intelligent man, with good sharp sight, or provided with spectacles, if necessary, can be very quickly taught to take temperature with sufficient accuracy."⁷

In a footnote, the translator of Dr Wunderlich's treatise, W. Bathurst Woodman,

History of thermometry

himself a physician, tells us that he has used a "registering thermometer" manufactured by Cassell.

Dr Wunderlich's ease of observation had to be greatly advanced by the invention of the maximum thermometer, which meant that an accurate reading was possible without leaving the thermometer in place. One may only conjecture the accuracy of temperature readings prior to its use. This facility certainly allowed the great number of observations that Wunderlich collected. At the same time, the germ theory of Pasteur gained in acceptance, indicating that fever, which heretofore had principally been considered a disease entity in itself, may have many underlying etiologies. The ability to take the temperature readily may well have aided in the developing interest in the mechanisms of fever.

The current clinical thermometer, in use at every bedside, is a familiar instrument to all physicians although the method of manufacture may be quite obscure to many of them. There are several thermometer manufacturers in the United States, but for purposes of illustration the method used by Becton-Dickinson will be outlined in detail.

There are ten steps in the production of a bedside thermometer: 1) The glass stem is formed with a standard size bore; 2) Three bubbles are formed in the center of the glass length; 3) The glass is cut in half at the center bubble; 4) The bulb glass which will become the mercury reservoir is fused to one end of the tube; 5) The bore and bulb are placed in an ultra-high vacuum chamber to remove all gas and moisture, before they are filled with mercury; 6) The top of the thermometer is added, the constriction to make it a maximum thermometer is formed, and the glass is annealed to ensure life-long accuracy; 7) The thermometer is calibrated at 98° and 106° to determine the scale length; 8) The scale is printed on the instrument and fused at a high temperature; 9) Certification for accuracy at

98°F, 102°F, and 106°F is completed; 10) The top chamber and excess mercury are removed and the thermometer is inspected and packaged. The thermometer is now ready for patient use.

Taking patients' temperatures has been a clinical procedure for over 370 years. At first the instruments were quite inaccurate and primitive. It was through the interest and patience of many scientists and physicians that the ability to take an accurate temperature was achieved. Santorio, with his demonstrated interest in quantification in medical studies, would be delighted with our thermometers and likely could only wonder why such a marvelous procedure as temperature-taking was not better performed. He would also be interested to know that thermometers used today can actually be used in "all parts of the body." □

Acknowledgments

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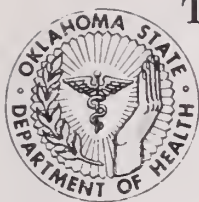
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News From The Oklahoma State Department of Health

Hearing screening questionnaire to go to parents of infants

Over 16.2 million Americans will eventually suffer from hearing loss. In infants this problem can impair speech and language development if it is not detected early.

During August 1983 a procedure was implemented in Oklahoma hospitals to assist in early detection of hearing loss in infants. An at-risk screening questionnaire is now available to identify those infants with a potential for hearing loss. The procedure was mandated in SB 574, passed by the 1982 Oklahoma Legislature.

The one-page questionnaire includes questions concerning family history of early hearing loss and complications suffered during pregnancy and delivery or after delivery.

Information will be requested from the parents at the same time birth certificate information is gathered, and will be mailed directly to the Oklahoma State Department of Health. The questionnaire and birth certificate remain separate documents; no information on the birth certificate can cause an infant to be deemed "hearing impaired."

Parents of infants at risk will be notified by the time the child is four months old. If a parent or legal guardian consents, the Commissioner of Health may then refer the information to appropriate service agencies for special services and educational opportunities.

All new parents will receive a copy of the questionnaire and a hearing checklist so they can chart their child's speech and language development through its early months.

Hearing loss is one of the most serious and least recognized disabilities, but early detection and intervention minimize language development delays in children. The at-risk screening questionnaire is expected to identify at least 80 % of the infants who will suffer a hearing impairment.

For more information about this program, contact the state health department's Pediatrics Division, Maternal and Child Health Service, (405) 271-4471. □

COMMUNICABLE DISEASES IN OKLAHOMA FOR SEPTEMBER 1983

Disease	September 1983	September 1982	August 1983	Total to Date	
				1983	1982
Amebiasis	1	1	3	8	11
Aseptic Meningitis	36	65	73	291	144
Brucellosis	1	1	1	6	5
Encephalitis, Infectious	2	13	7	27	32
Gonorrhea (Use Form ODH-228)	1,275	1,517	1,488	11,759	12,077
Hepatitis A	55	66	58	395	539
Hepatitis B	22	40	36	238	262
Hepatitis Unspecified	21	23	19	184	194
Malaria	1	1	—	8	8
Measles (Rubeola)	—	6	—	1	27
Meningococcal Infections	2	—	—	27	22
Pertussis	32	—	74	237	5
Rabies (Animal)	1	13	7	91	159
Rocky Mountain Spotted Fever	19	5	32	207	81
Rubella	—	—	—	—	3
Salmonellosis	77	75	63	424	317
Shigellosis	31	48	30	168	281
Syphilis (Use Form ODH-228)	15	23	17	175	152
Tetanus	—	—	—	—	1
Tuberculosis	23	4	40	189	257
Tularemia	5	3	4	27	25
Typhoid Fever	—	—	—	3	2



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Successful embryo transfers in primates offer new hope

Results of a recent primate study offer hope that women with ovaries may someday be able to carry and deliver babies.

Gary D. Hodgen, PhD, of the National Institute of Child Health and Human Development, has announced in the *Journal of the American Medical Association (JAMA)* the successful transfer of surrogate embryos, combined with estrogen-progesterone therapy, in rhesus monkeys.

"This article describes the first successful collection, to our knowledge, of in vivo fertilized primate embryos transferred to females lacking ovaries and who received estrogen-

progesterone implants to achieve endometrial synchrony, with the birth of four normal neonates," Hodgen writes.

"These findings encourage clinical investigations employing SET (surrogate embryo transfer) combined with a similar regimen of hormonal replacement therapy, thereby developing new potential for childbearing even in women lacking ovarian function," he says.

"This primate model demonstrates for the first time, the biologic feasibility of simulating the essential hormonal milieu of the fertile menstrual cycle to accommodate SET to females lacking intrinsic ovarian function," Hodgen adds.

Commenting on the findings, in vitro fertilization pioneer Howard W. Jones, Jr, MD, of Eastern Virginia Medical School in Norfolk, says, "A solution for the patient with absent or nonfunctioning ovaries is more difficult because it requires not only the donation of an egg to be fertilized by the sperm of the husband but the exogenous administration of ovarian substances without which implantation and early embryonic development cannot occur. . . . It is to this solution that the brilliant experiments of Hodgen are directed.

"He has shown that in a primate totally deprived of ovarian function, proper doses of estrogen and progesterone alone can provide a suitable environment for nidation and development. . . . Therefore, the woman without ovarian function can realistically consider a transfer of a donor egg."

Also commenting on the finding, medical ethicist LeRoy Walters, PhD, of Georgetown University, cautions that there are "at least three general arenas of potential social impact for SET: the family unit; the medical care provision system; and the commercial sphere."

He suggests that SET may be more satisfactory than traditional adoption or surrogate-

(continued on page 431)

Hospital medical staffs to organize at February meeting

The Oklahoma State Medical Association Ad Hoc Committee on Hospital Medical Staff Section would like to announce the first statewide organizational meeting to be held in Oklahoma City on February 4, 1984.

The chief of staff of each hospital will be contacted by letter with all the detailed information concerning the meeting. Each hospital medical staff will be allowed to send one representative provided he is an OSMA member.

The hospital medical staff section movement was finalized during the 1982 Interim Meeting of the AMA House of Delegates when it was officially established. The HMSS has a governing council, including one delegate and one alternate delegate to the AMA House of Delegates. The members of the HMSS must be members of the AMA and have clinical privileges at the institutions they represent.

If you are interested in participating in the OSMA HMSS, please contact your chief of staff as more information will be mailed to him soon. □

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Potential heart disease victims should be screened by age 20

Coronary heart disease can be controlled if more stringent detection programs are implemented at earlier ages, and if care is extended to a patient's family, according to reports in the *Journal of the American Medical Association (JAMA)*.

An initial blood screening for abnormalities that could point to heart problems should be done at or before 20 years of age, says an AMA Council on Scientific Affairs report. Such screenings might include singling out patients with only slightly elevated levels of blood lipids "because the majority of patients with

coronary heart disease emerge from this group," the report states.

In an accompanying report, University of North Carolina researchers say that screening for coronary heart disease should concentrate on the families of heart patients, rather than on the general population.

"To the extent that total plasma cholesterol, triglyceride, high density lipoprotein cholesterol, and low density lipoprotein cholesterol levels disclose highly significant 'cultural inheritance' (environmental effect) in families, risk factor modification may be most successful when it occurs throughout the family environment," say John A. Morrison, PhD, and colleagues. "Presumably, shared genetic and environmental factors that elevate levels of triglycerides and/or cholesterol in such families can be identified in subjects and their first degree relatives, allowing for early intervention."

Morrison studied about 8,000 offspring and siblings of persons having either normal or high cholesterol and triglyceride levels. They found that the incidence of hypercholesterolemia and hypertriglyceridemia in offspring and siblings increased with the severity of these conditions in their affected relatives.

"Those patients found to have persistent elevations of total cholesterol and low-density lipoprotein cholesterol levels (those readings ranking in the top 10% of all such measurements performed) should be advised to have their siblings and offspring tested," the report concludes. □

Successful (continued from page 429)

motherhood because it "allows both members of the adopting couple to be biologically involved" in the pregnancy. He warns, however, that SET may become a high-technology procedure available only to those able to afford it.

The commercial potential of the procedure clearly raises the most difficult questions, Walters suggests. "Strenuous opposition would be likely to greet any proposal to establish a commercial human-embryo bank on the ground that the sale of human embryos for adoption is more like the (prohibited) sale of infants for adoption than the (permitted) selling of human semen or blood," he says. "At the very least, society may want to require that all prospective germ-cell or embryo donors receive careful screening," he adds. □

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Physicians overuse antibiotics in treating simple sore throats

A recent comprehensive study in Rhode Island suggests that simple sore throats are often treated inappropriately and inefficiently.

In the study, more than 157,000 throat cultures were done for a population of 930,000 in 1980; it was also shown that 87% of primary care physicians prescribed antibiotic therapy before culture results were known. Furthermore, some 40% continued antibiotic therapy for 10 days regardless of culture results.

"Antibiotics are frequently given when cultures are taken, and such therapy is often not stopped when culture results are negative," say Scott D. Holmberg, MD, and Gerald A. Fiach, MD, MPH. "Acute rheumatic fever (ARF) is rare in the state," they add. "The costs of present practices are high while the benefits of these practices relative to control of ARF are doubtful."

Accepted strategies for management of simple sore throat are promulgated by the American Heart Association. They were devised at a

time when acute rheumatic fever was a much greater health hazard than it is today. The incidence of the disease has plummeted during this century and has dropped to as low as one case per 200,000 school-age children per year in parts of the United States. The decline of ARF is related to a combination of factors including improved living standards, antibiotics, and changes in the rheumatogenic potential of current "strep" strains. Thus, throat cultures presumably should be used more to prevent extraneous antibiotic treatment than to prevent the rare case of acute rheumatic fever.

The authors of the study speculate that physicians "probably routinely culture out of habit, in deference to the expectations of patients and parents, or in accord with professional recommendations."

They add that physicians probably begin antibiotic therapy immediately so their patients are spared extra office visits. □

Video display terminals pose no serious threat to operators

Video display terminals (VDTs) are not a radiation hazard, and they have not been shown to cause cataracts, permanent damage to vision, miscarriages, or birth defects.

This and other information about VDTs is the subject of a report released by the American Council on Science and Health (ACSH), an independent scientific organization. The report goes on to say that some of the more than seven million Americans who use VDTs on the job do report temporary health problems. Among these are burning or itching eyes, headaches, and back or shoulder pain. Although poor design or inadequate maintenance of a terminal can contribute to such problems, the way the equipment is used in a particular workplace may also be at fault.

"Environmental features such as furniture and light levels that are well suited for conventional office work may be poorly suited for extensive use of video display terminals," the ACSH report states.

If VDTs are introduced into an office

without suitable office modifications, problems may result from improper illumination, glare, or poorly designed workstations that do not permit operators to see and reach the keyboard, screen, and auxiliary equipment comfortably.

"Health complaints that arise in an office where computer terminals are used may also result from psychological factors," says ACSH Research Associate Kathleen A. Meister. "In some cases, the introduction of computers is accompanied by major changes in the structure of people's jobs, by stricter supervision or increased isolation of workers, or by the possibility of layoffs. Problems that are actually caused by factors such as these may be mistakenly blamed on the terminals, simply because the equipment is new and conspicuous."

A single complimentary copy of the report, "Health and Safety Aspects of Video Display Terminals," can be obtained from ACSH, 47 Maple Street, Summit, New Jersey 07901, by sending a self-addressed, stamped, (37 cents), business size (#10) envelope.

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Removal of large gallstones associated with cancer prevention

The removal of large gallstones, whether or not they cause gallbladder problems, might be warranted as a cancer prevention measure.

That is a conclusion of Andrew K. Diehl, MD, MSc, in a report recently published in the *Journal of the American Medical Association (JAMA)*. The University of Texas, San Antonio, researcher conducted a study of gallbladder disease and found that patients with stones 3 cm (1.2 in) or larger were ten times more likely to have cancer than patients with stones smaller than 1 cm.

"The major finding of this study is the strong association of gallbladder cancer with large gallstones," Diehl says. "Second, the relationship is consistent in every subgroup examined and in most cases is statistically significant. Finally, a 'biologic gradient' is strongly suggested: as stone size increases, so, too, does cancer risk."

Having studied 227 persons with various gallbladder- and nongallbladder-related maladies, the researcher concedes that more studies are needed before a patient elects to have his gallbladder removed because of stones that do not cause symptoms.

"Even in the best centers, the risks of chole-

cystectomy would likely outweigh the benefits from cancer prevention," he says. "On the other hand, if measurable factors in addition to cholelithiasis could be elucidated, that recognize persons at especially high risk for cancer, prophylactic surgery might be justified."

Gallbladder cancer accounts for 2,400 deaths annually in the United States. Three times as many women as men have stones. Some 20 million Americans have either symptomatic or asymptomatic gallstone disease. □

Cesarean sections lower death rate among some high-risk infants

The dramatic increase in cesarean sections performed in the United States during the last decade may be partially responsible for improved survival rates among some high-risk infants, says Ben P. Sachs, MB, from Beth Israel Hospital, Boston.

Reporting on a study carried out while he was at the Centers for Disease Control (CDC), Atlanta, Sachs suggests that cesarean section reduces neonatal mortality among all breech-delivered infants and among low-birth-weight infants delivered in the vertex position.

Findings from a CDC analysis of 392,241 singleton deliveries in Georgia from 1974 through 1978, published in the *Journal of the American Medical Association (JAMA)*, show that the risk of death for breech infants in the lowest weight groups (1,000 g to 2,500 g) was almost 2.5 times greater for those delivered vaginally than for those delivered by cesarean section. The risk declined as birth weight increased toward 4,000 g.

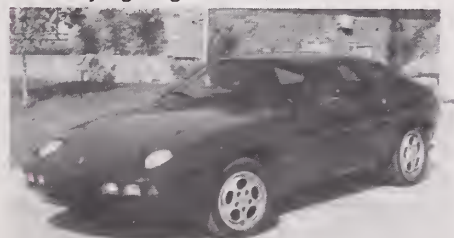
High-risk vertex infants weighing 1,000 to 1,500 g had the best outcome when delivered by cesarean section in specialized perinatal centers, the researcher points out.

Cesarean section is not without its own risks, Sachs adds. Current maternal mortality directly related to cesarean sections in Georgia is 5.9 per 10,000 procedures. But if neonatal mortality can be shown to decline significantly as a result of the increased cesarean section rate, says Sachs, then the benefits may outweigh the increased risk of maternal infection and death as well as the considerable costs associated with surgery, longer hospital stays, and protracted convalescence. □

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Study shows CPR skills drop 60% in first year; retraining urged

Companies offering cardiopulmonary resuscitation (CPR) training should concentrate their efforts on fewer employees and give them refresher training more often, according to a study on CPR skills retention appearing in *Annals of Emergency Medicine*.

Training also should focus on younger employees with previous first aid training. The remaining employees could attend an educational program concentrating on the early recognition of heart attack, entry into the emergency care system, and availability of trained help should a collapse occur.

W.A. Tweed, MD, lead author of the study, also points out the need for further research in the area of skills deterioration, as well as effective methods of retraining and optimal time for retraining.

The study reviewed the skills of telephone company employees who had undergone an

eight-hour CPR training program in 1979-1980. In 1981, a random sample of 40 employees was selected from the original 950 for a surprise retest.

Results of the retest showed that in lay basic rescuers after one year, CPR skills had deteriorated to 40% of the post-training level. Complete details and results of the study appear in *Annals*, the monthly clinical journal of the American College of Emergency Physicians (ACEP).

The original test and the retest scored the number of adequate ventilations, adequate compressions, wrong hand positions, timing, assessment time, call for help, and adequacy of carotid pulse check. "Adequate" was defined by the criteria of the American Heart Association and the Canadian Heart Foundation. The same recording manikins were used in both tests.

□

In Memoriam

1982

<i>Berget H. Blocksom, MD</i>	<i>December 26</i>
<i>Harold T. Baugh, MD</i>	<i>December 28</i>

1983

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<i>John R. Little, MD</i>	<i>February 11</i>
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<i>Virgil Ray Forester, MD</i>	<i>March 8</i>
<i>George Ross, MD</i>	<i>March 11</i>
<i>Holice B. Powell, MD</i>	<i>March 18</i>
<i>John A. Brasfield, MD</i>	<i>April 15</i>
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<i>Gilbert E. Haslam, Jr, MD</i>	<i>June 15</i>
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<i>Richard D. Mullett, MD</i>	<i>June 28</i>
<i>Aaron C. Little, MD</i>	<i>July 1</i>
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<i>Hillard E. Denyer, MD</i>	<i>August 8</i>
<i>Edward A. Allgood, MD</i>	<i>August 18</i>
<i>Hugh E. Wilson III, MD</i>	<i>August 27</i>
<i>Harold J. Black, MD</i>	<i>September 1</i>

Book Review

Kuru: Early Letters and Field-Notes from the Collection of D. Carleton Gajdusek. Edited by Judith Farquhar and D. Carleton Gajdusek. New York: Raven Press, 1981, pp 338, with illustrations, \$32.00.

D. Carleton Gajdusek won the 1976 Nobel Prize in Physiology or Medicine for his investigations of kuru, a chronic degenerative disease of the central nervous system caused by a slow virus infection. It is the first disease of humans proved to be due to such an infection.

The early details of an epidemic in isolated portions of New Guinea were reported in December 1956. Gajdusek visited New Guinea in order to plan a return there for studies on child growth and disease patterns in primitive societies. Upon learning about the outbreak of kuru, he contacted the medical officer who first reported it, Dr Vincent Zigas, and they immediately visited the affected region.

Gajdusek initiated a record of case histories and clinical observations as well as the collection of specimens to be sent to Australia and to America. In collaboration with Zigas and local personnel, he established a special hospital in the bush for kuru patients and organized a program to administer empirical treatments in

the hope that one or another of these might prove effective.

The book begins with a preface by Judith Farquhar, one of the editors. This is followed by an editorial note by Ms Farquhar and Dr Gajdusek and an introduction by Gajdusek. After an explanatory introduction which covers a longer period, then the correspondence, the letters and field notes appear almost verbatim and in chronological order. They cover the period December 26, 1956 through January 28, 1958, and demonstrate vividly the achievements of Gajdusek, Zigas, and their associates in bringing kuru to the attention of the world. These entries confirm the energy and enthusiasm of Gajdusek and his endless determination in the project. What he and his co-workers were able to achieve under the most primitive conditions is little short of amazing. Particularly interesting are the sections describing the explorations made for delineating the boundaries of kuru in the region. The documents contain interesting reports on various conditions and detailed clinical-epidemiologic reports.

Mail was the primary means that Gajdusek and his team had for communicating with the civilized world. This helps to explain why many of the letters are lengthy and repetitive, often containing a variety of requests for equipment and supplies in addition to discussions of local administrative problems. In places this makes for rather heavy going and tends to obscure the fascinating story which is unfolding.

Gajdusek is not immodest in proclaiming the importance of the work. He states in the introduction, "The events recorded in these letters and field-notes inspired and shaped all future work on slow virus infections of man, and led to a major breakthrough in the study of chronic and hereditary degenerative diseases of the human central nervous system." He also tells us in the introduction that he favored an infectious etiology for the disease.

Although kuru was rapidly diagnosed as a neurological disorder, it appears from the correspondence that its possible infectious etiology was essentially dismissed quite early, and efforts to identify a possible toxic cause were intensified. There is little mention of cannibalism, now known to be the key means of transmission, and the comments about it are retrospective and contained in the introduction. There is also no mention of the previously published work on scrapie agent, a slow virus

infection of sheep, which had been known for some years.

The correspondence makes repeated reference to the conflicts between Gajdusek and Australian administrative officials, particularly the renowned Sir MacFarlane Burnet of Melbourne who, according to his own statements, had planned to have his own staff study kuru but was preempted by Gajdusek. It would appear that completion of the project occurred because of the dogged persistence of Gajdusek in the face of repeated acrimonious accusations. Important also was the support of Gajdusek by Dr Joe Smadel of the National Institutes of Health.

The photographs are technically excellent and revealing, and complement the text.

As stated in the preface, "The materials collected in this book . . . provide a rare opportunity to observe the operations of scientific thought in grappling with a new and bizarre clinical entity."

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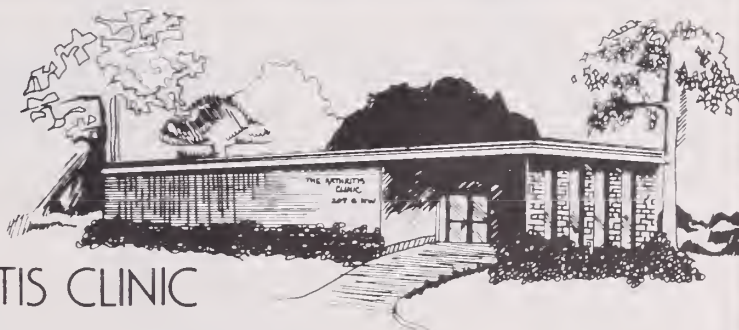
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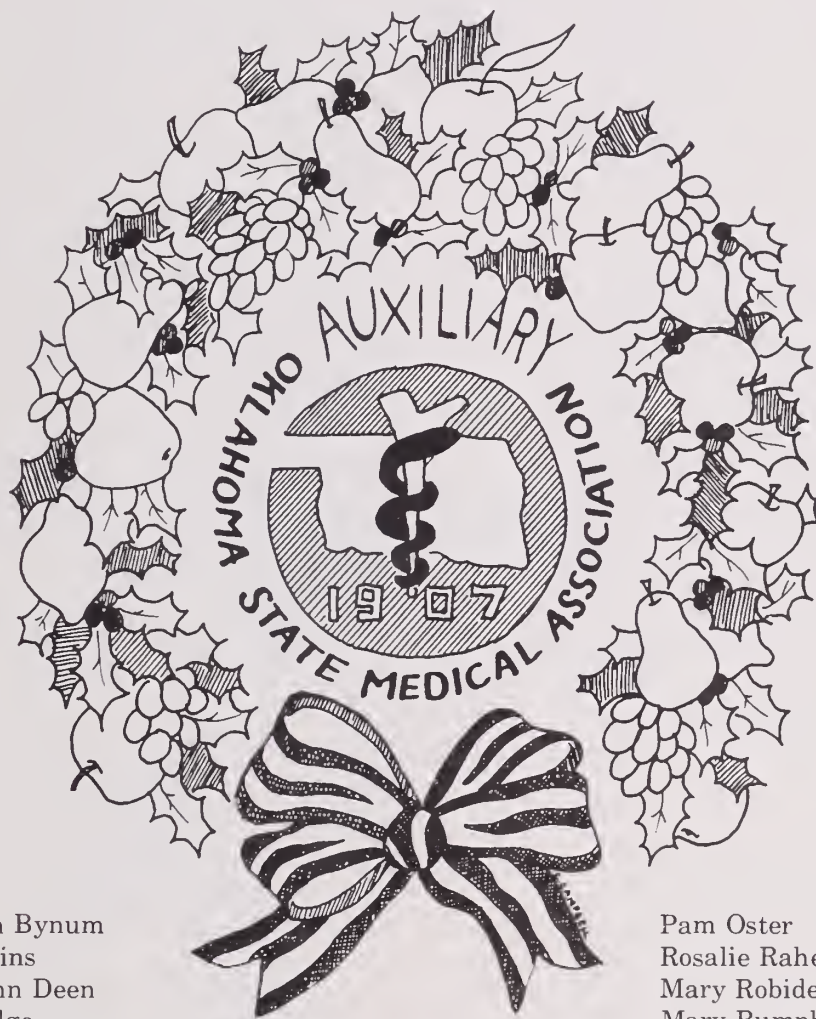
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Kelsey Walters
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■ **The Retired Doctors Club in Oklahoma City** welcomed a new member, Jim Taylor, MD, and an out-of-town guest, Clifford Moore, MD, of Stillwater, at their October meeting. Twenty-two members attended the luncheon meeting at Baptist Hospital, and Ed Kelsay, OSMA staff legal counsel, spoke on how to avoid malpractice lawsuits. Dr Hervey Foerster, club president, extended again his open invitation to all retired doctors to attend the monthly meetings.

■ **Two cases of angioimmunoblastic lymphadenopathy with dysproteinemia (AILD)** occurring in homosexual men with symptoms of acquired immune deficiency syndrome (AIDS) have been reported in the *Archives of Pathology and Laboratory Medicine*. "The immune system is somehow defective in both entities," say Walter Blumenfeld, MD, and Jay H. Beckstead, MD, from the University of California School of Medicine, San Francisco. The two diseases share many clinical and laboratory findings, but the relationship between them has not been clearly defined. "AILD may be one additional manifestation of AIDS in a subset of patients with that disorder," the authors say.

■ **The term "wrongful life"** correctly applies to a defective child's cause of action, alleging that the physician failed to inform and advise the parents adequately concerning foreseeable fetal risks from genetic or other congenital defects, points out AMA attorney Susan M. Schmidt in a recent *Journal of the American Medical Association*. "Wrongful life actions generally have not received favorable judicial or legislative response," she adds, but says this might change as prenatal testing and genetic counseling become more refined.

■ **Chewing one's tobacco is no safer than smoking it**, according to W. Frederick McGuirt, MD, in the *Archives of Otolaryngology*. His study at the Bowman Gray School of Medicine, Winston-Salem, NC, of 290 patients with oral tumors showed that 57 chewed snuff exclusive of any use of cigarettes, pipes, or alcohol. They were primarily white women older than 60 years who had "dipped" snuff for over 40 years. More than 49% died of their disease or of complications of treatment (surgery, radiation), and only about 25% were alive and free of disease after five years. The currently popular switch from smoked to smokeless tobacco will merely result in a change in the site of tobacco-related cancer, McGuirt warns.

■ **Samuel Sepkowitz, MD, Oklahoma City pediatrician** and clinical professor of pediatrics at the University of Oklahoma College of Medicine, recently submitted a letter to the editor of *The New England Journal of Medicine*. The letter, headlined "Intensive Care of Low-Birth-Weight Infants," was published in the October 27 issue. On the same topic, Sepkowitz's manuscript "An Appraisal of Neonatal Intensive Care Unit Weight-Specific Mortality Rates" appeared in the October 1983 issue of the OSMA's *Journal*.

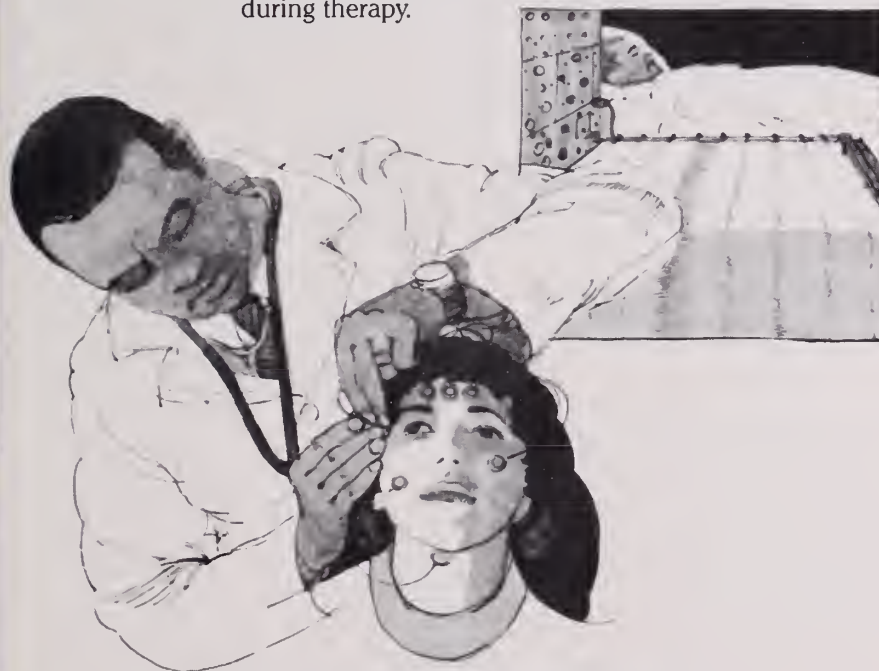
■ **Three Oklahomans were recently elected Fellows** of the American College of Physicians (ACP). M. Dewayne Andrews, MD, Oklahoma City, and Arnold L. Katz, MD, and Lee N. Newcomer, MD, Tulsa, will be formally inducted at the College's Annual Session in Atlanta, Georgia, April 26-29, 1984. Election to fellowship in the national organization signifies that a physician has been recognized by his colleagues as having attained a high level of scholarship and achievement in internal medicine.

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sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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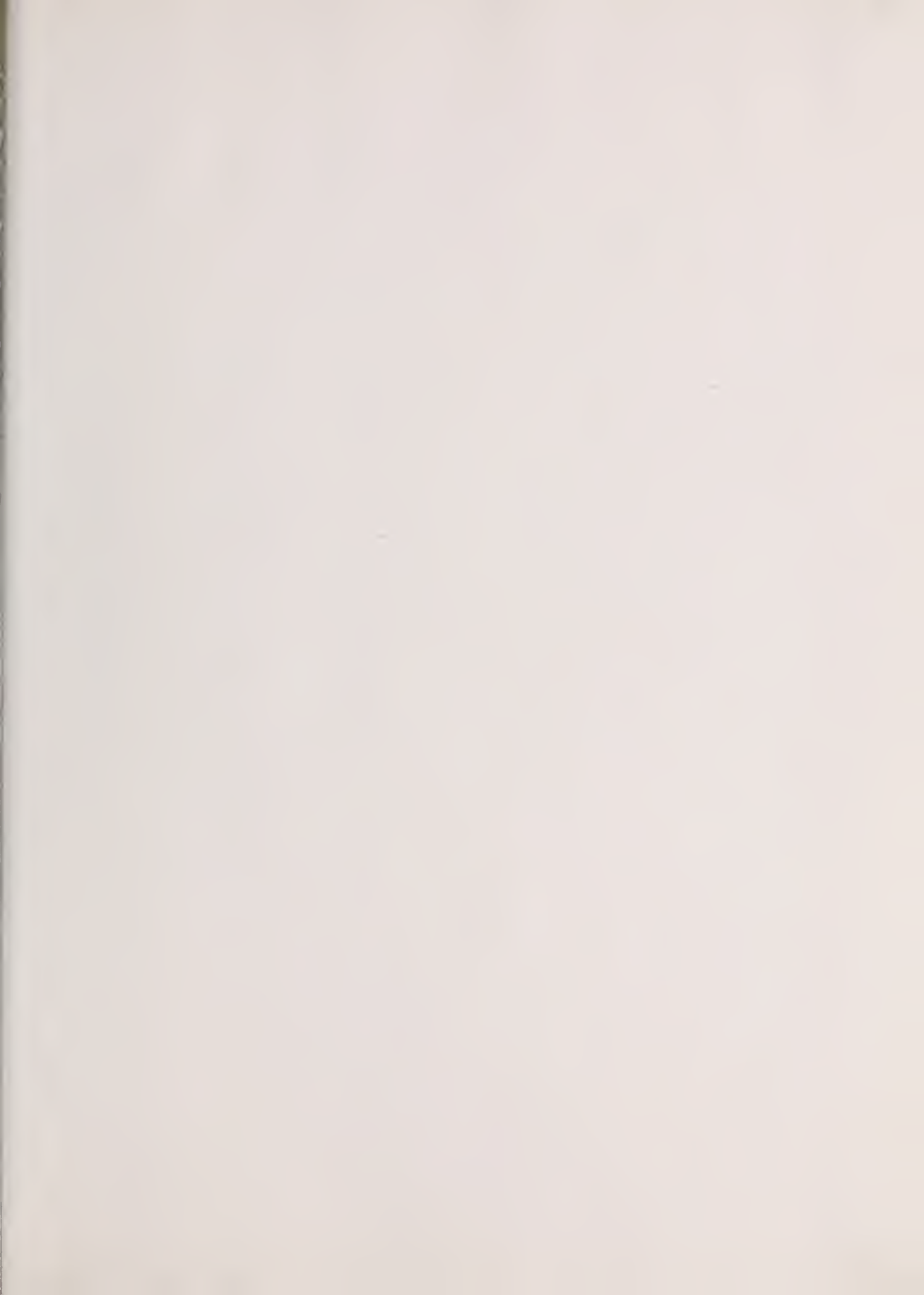
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